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THE PROGNOSTIC VALUE OF "MOBILITY" DURING THE FIRST TWO YEARS OF HOSPITALIZATION FOR MENTAL DISORDER*

BY ARCHIE CRANDELL, M. D., JOSEPH ZUBIN, Ph.D.,
FRED A. METTLER, M. D., AND NOREEN D. LOGAN, M. A.

With the growing interest in the evaluation of therapies for early as well as for chronic hospitalized patients, more and more attention is being paid to techniques which may predict outcome, so that the improvement rate in a treated group of patients may be compared with the expected "spontaneous" outcome of such patients had they remained untreated.

While the prognosis in chronic cases is not generally as good as in early cases, there are nevertheless many chronic mental patients who eventually improve, even without the help of a specific therapy. The prognosis of such outcome is at present principally based on clinical experience, as expressed for the most part in the discharge rates given by hospitals for various diagnostic categories. Any help toward more exact prognosis that can be afforded by alternative methods, ought to help to stabilize prognosis and would offer the necessary base lines for evaluating improvement under a specific therapy. Psychological tests have been found helpful in this connection, and personal history factors, such as age, duration of illness, type of onset, and a variety of rating scales for personality traits have been used by various investigators with some success. Specifically, the development of a satisfactory technique based upon a variety of objective factors should make it possible to compare quickly and objectively the prognostic characteristics of large and diverse hospital populations; and if it were possible to do this without the necessity of employing highly skilled professional personnel, the time and efforts of the latter could be maximally employed. While such a technique would not supplant the necessity for developing individual prognoses by professional personal interview, it would be very valuable as a screening method and would prevent sliding of criteria in the use of rating scales and psychiatric interviews.

In the design of the Columbia-Greystone projects careful comparisons were made between the pre- and post-operative conditions of the patients with regard to a large number of variables, it being

*Funds for this study were made available from the National Institute of Mental Health, MH 305C, responsible investigator Archie Crandell.

assumed that not only are separate control groups necessary but that each individual must to a large extent serve as his own "control." It gradually became apparent (*Psychosurgical Problems.*[1] The Columbia Greystone Associates, 1952, Fig. 1) that there was a strong tendency for the post-operative discharge patterns of these patients to repeat their pre-operative patterns. When the pre- and post-operative behavior of the Greystone cases was compared in this regard with that of another series at Rockland (which had shown very little post-operative mobility, *Ibid.,* Fig. 3), it became clear that populations which show marked pre-operative differences also show them post-operatively. In an effort to give some objective expression to this rule an "occlusive index" was developed (*Ibid.,* Fig. 56). This index, designed to reflect the degree of mobility in groups of chronic patients prior to the initiation of psychosurgery, was based on the average number of uninterrupted months of hospitalization shown by the patients up to the date of the initiation of the project. This index was found to be related negatively to outcome; that is, groups of patients with short durations of uninterrupted hospitalization tended to fare better *in eventual outcome* than patients with longer durations of uninterrupted hospitalization. This index was calculated for each group by dividing the cumulative number of months of hospitalization for the entire group by the total number of moves out of the hospital. A move was defined as an absence from the hospital lasting 14 consecutive days or longer. Patients who had many interruptions in their hospital residence (greater mobility) would, of course, have more moves and a smaller index; and they were found to have higher improvement rates than those who had fewer moves and consequently longer average durations of hospitalization (lesser mobility).

To the best of the writers' knowledge this was the first attempt made to direct attention, for prognostic purposes, to the degree of mobility (movement in and out of the hospital) or stagnation exhibited by the patient during his early hospitalization period. Some patients stay continuously in the hospital without any home visits, some are discharged shortly after admission and never return, others make frequent visits home for longer or shorter periods, while still others have periods of intermittent remission during which they are sufficiently well to be discharged, only to be readmitted later. Such mobility may reflect either the interest of the

family in the patient, the desire for improvement on the part of the patient, characteristic phases of the disease process, the effect of therapy, or other factors.

In formulating the "occlusive index," the writers were careful to point out that it was applicable only to groups of patients and not to individual patients; and, indeed, efforts to narrow this device down to particular cases proved that for such purposes additional data had to be collected. One may speculate as to whether higher or lower mobility is more desirable, or as to whether the relationship between mobility and eventual outcome is linear or curvilinear, i. e., whether patients with little or much mobility would show poor outcome while those of medium mobility showed good outcome. But such speculations cannot be clarified until objective data on these questions become available.

When the attempt was made to apply the "occlusive index" to individuals instead of groups it became apparent that it was impossible to compute individual indices for patients who stayed in the hospital continuously, since in their cases, the number of months of hospitalization would have to be divided by zero. Second, the occlusive index employed the total time elapsed from the date of first admission to the date when the index was computed, and the total time involved varied considerably from patient to patient. While this did not seem to interfere with the prognostic value of the "occlusive index" in populations such as were under study, it must be considered that, to be generally useful, a standard, uniform duration of hospitalization provides a more satisfactory base for computing an index. This duration should not exceed two years, since by the end of two years from 70 to 90 per cent of first admissions tend either to be recovered or improved, although some of them subsequently are readmitted. Furthermore, there is some recent evidence (Zubin, Hamwi and Windle, 1953[2]) to indicate that the prognosis for chronic cases should be based on criteria different from those which are of value for early cases. To meet these needs, a new figure designated here as the "immobility index"* was devised to measure more directly the prognostic value of an individual patient's mobility during the first two years following his initial hospitalization. The prognostic value of this two-year index

*The reason for using "immobility" rather than "mobility" inheres in the desire to keep the direction of the old index, the occlusive index, and that of the new index, the same. Both of them are negatively related to outcome.

has been validated in this study against immediate outcome at the end of two years, and at five, eight and 13-year periods but may, of course, be used for outcome at any other selected follow-up period.

To investigate the merits of this index as a prognostic agent, a study was undertaken of the total number of admissions to New Jersey State Hospital at Greystone Park for the calendar year of 1939* to see whether an unselected group of patients would show any relationship between this immobility index and outcome. The case histories of all the admissions for 1939 were sampled to obtain three independent random samples, consisting of 20 per cent, 27 per cent and 20 per cent respectively of the total admissions.

The total number of patients admitted during that year and the numbers found in the first, second and third samples are shown in Table 1.

Table 1. Number of Patients Obtained in Sample I, Sample II and Sample III of All Patients Admitted to the New Jersey State Hospital at Greystone Park, 1939

Samples	Patients selected		Patients found to satisfy criteria	
	Number	Per cent of total	Number	Per cent of sample
Sample I	257	19.94	62	24.2
Sample II	345	26.76	84	24.2
Sample III	256	19.86	54	21.0
Total	858	66.56	200	23.3
Total admitted	1,289	100.00		

Of the 1,289 patients who were admitted to the hospital during 1939, 858 were caught in the sampling net, 20 per cent falling into the first and into the third sample, respectively, and 27 per cent into the second sample. To get groups comparable to those on which the occlusive index was based, the following criteria, utilized for the occlusive index cases, were applied to the patients in each sample: (1). *Age*: 19 years, six months, to 50 years, five months. (2). *Diagnosis*: functional psychosis (schizophrenia, manic-depres-

*This period was chosen to minimize the possible interference effects of therapy. During the period under consideration military and economic factors reduced the opportunity for active therapeutic programs in most state hospitals to a minimum. It should also be pointed out that spot checks on population samples indicated that there was no substantial difference in the therapeutic treatment in those populations which ultimately showed low and high immobility indices.

sive psychosis, paranoia, involutional melancholia). (3). *Absence of Physical Involvement*: All patients suffering from active tuberculosis or other physical illnesses were excluded. (4). *Absence of Exogenous Factors*: All patients suffering from chronic alcoholism and drug addiction were excluded.

Only those patients in each sample who satisfied the foregoing criteria were included in this study. The criteria were applied in the following sequence:

If the person caught in the sampling net was found to be deceased on April 1, 1952, he was eliminated from the sample. If he was found to be alive, his diagnosis was looked into, and if this met the criterion for selection, his age was checked. Finally the remaining criteria were investigated. If he met all the requirements for acceptance, he was included in the sample. The numbers of patients in each sample meeting these criteria are also shown in Table 1. About one-fourth of each sample were found to satisfy the criteria for inclusion.

The number of patients rejected, and the bases for rejection are given in Table 2.

Table 2. Number of patients rejected from study by cause of rejection

	Deceased	Age	Diagnosis	Project cases*	Active physical diseases	Exogenous factors	Incomplete records	Total
Sample I.....	86	24	74	2	3	2	4	195
Sample II	117	19	113	0	2	1	9	261
Sample III	88	15	86	3	3	0	7	202
Total	291	58	273	5	8	3	20	658

*Columbia Greystone Studies.

It will be noted that the numbers rejected for various causes did not differ materially from sample to sample. This adds confidence to the belief that the selected patients were truly random samples of the total, and that the factors of survival, age, diagnosis, etc., are not sources of bias interfering with the inferences which were made subsequently. It should also be pointed out in this connection that this study is essentially a study of first admissions and readmissions during 1939, who survived from 1939 to April 1, 1952 (or for a comparable period of 13 years following their first admissions for those who were readmissions in 1939), those dying

during this period being rejected. The writers are certain, of course, about the survival of the patients who were still hospitalized in 1952; they are not so certain about those who improved and were discharged, since deaths of former patients are not invariably reported. It is hoped at some future time to search the mortality statistics of the State of New Jersey and the Greater New York metropolitan area to see how many of the improved discharged patients survived and how long they survived. (A small sampling study of the discharged patients was actually conducted and is discussed in the following.) The difficulty presented by the factor of mortality did not occur with reference to readmissions, since the New Jersey State Hospital at Greystone Park routinely receives inquiries from all hospitals to which a former Greystone Park patient is subsequently admitted. Thus, the study may be regarded as covering all hospitalized patients who survived 13 years from the date of first admission.

It should also be noted at this point that a small number of patients (52) were not first admissions during 1939, having been admitted previously. In the calculations of their hospital stays, the actual years of their first admissions were used.

The analysis of these data was made in two steps. First, the immobility index was computed according to the specifications laid down by the Columbia Greystone Associates for the occlusive index but was modified to permit the computation of individual indices for each patient. Second, the factors underlying this index, (1) number of days of actual hospitalization, (2) number of days out of the hospital and (3) number of moves, were analyzed separately to see their relationship to outcome.

The immobility indices,* based on the first two years following first admission to a mental hospital: for the total group and each of the three samples, by outcome status on two-year, five-year, eight-year and 13-year follow-up, are shown in Table 3 and Figure 1.

In addition, the status of each patient as of April 1, 1952 is also given. In order to make the index applicable to individual patients, it was necessary to modify the procedure for computing it

*The immobility index was computed, based on the first year, first two years, three years and four years of hospital residence. Since the bulk of the patients who eventually are discharged leave the hospital by the end of the second year, the index does not change appreciably after the first two years. For this reason, the index based on the first two years of hospital residence, was selected.

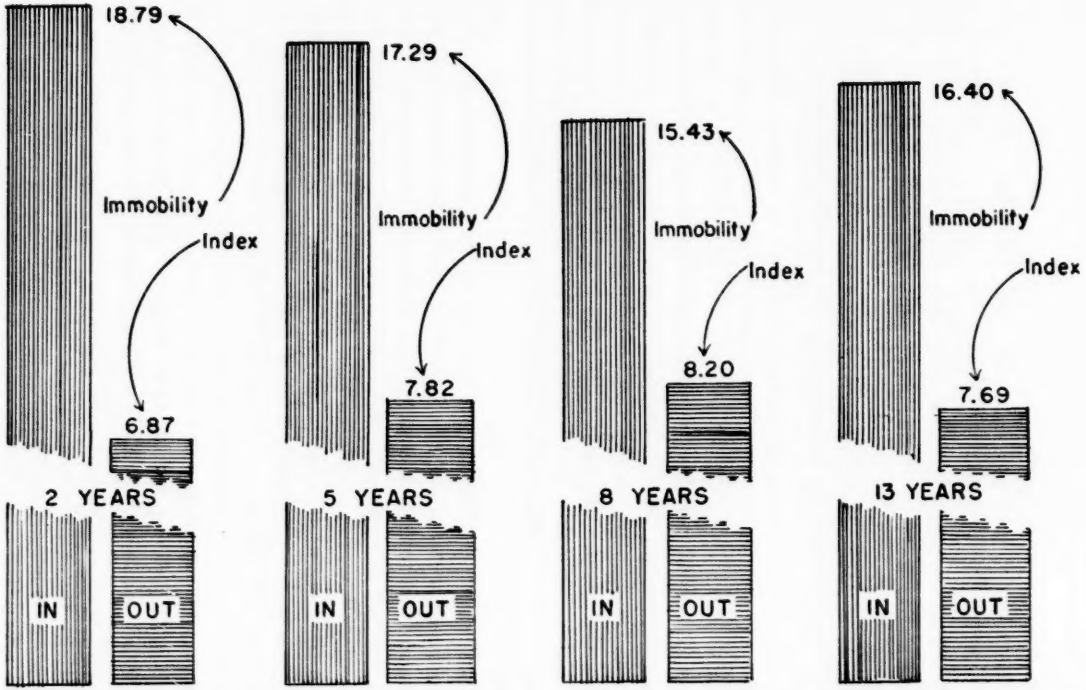

Figure 1. Bar graph giving the immobility indices for patients in and out of the hospital two, five, eight and 13 years after their date of first admission. It will be observed that the indices are practically identical for all periods, indicating that the uniform trend is already well established by the end of the initial two-year period.

Table 3. Means (M) and Variances (σ^2) of the Immobility Indices for the In-Group and the Out-Group by Period of Follow-up

	Follow-up Periods									
	Immediate (2 yrs.)		5 years		8 years		13 years		4/1/52	
	M	σ^2	M	σ^2	M	σ^2	M	σ^2	M	σ^2
In-group	18.79	69.79	17.29	74.79	15.43	80.64	16.45	78.45	16.13	77.91
Out-group	6.87	26.77	7.82	41.71	8.20	47.56	7.69	40.40	7.80	42.96
F*		157.69		74.30		40.60		65.27		57.49
P		<.01		<.01		<.01		<.01		<.01

*The F ratios are obtained by comparing the variance between the means for the "in" and "out" group with the within group variance. The immobility index for individuals is obtained by dividing the total number of days of hospitalization within the first two years after the first admission by the number of moves into the hospital, counting the first admission as move 1. The number of days spent on visit, if such visits lasted for a fortnight or more, is not included in number of days of hospitalization.

by substituting the number of moves *into* the hospital (including the first admission) for the number of moves *out* of the hospital, which was the figure used by the Columbia Greystone Associates. By using the number of moves into the hospital, the denominator of this index can never fall below 1. This modified index will be designated as the "immobility index" and is defined in the legend of Table 3.

The immobility index for each of the three samples varies but little, being approximately 10 months for each move for each of the samples and the total. A comparison of the indices for the "in's" and for the "out's" (patients on discharge status out of the hospital on date of follow-up) indicates that the ratio of the index of the "in's" to the "out's" is approximately 2.00 and shows little variation. The statistical significance of these differences is shown in the last row of Table 3.

In each case, the immobility index for the "in's" was significantly greater than the index for the "out's." This is in keeping with the earlier findings of the Columbia Greystone Associates for the occlusive index, but it should be remembered that, whereas the earlier study dealt with chronic mental patients only, the present study deals with all the admissions during the calendar year of 1939, both early cases and subsequently chronic patients being included. Since the bulk of the early cases leave the hospital within three to six months after admission, their indices are likely to be lower than those of patients who stay in for the entire period of the first two

years. If one eliminates from the 13-year follow-up those patients who remained hospitalized less than four months during the first two years following their first admission, the immobility indices are not altered appreciably. For the in-group the index is 17.35 and for the out-group it is 9.31. This indicates that the relationship between the immobility index and outcome is not artificially produced by those patients who leave the hospital after a very short stay and never return.

To examine the nature of this index, the underlying factors of which it is composed, and its applicability to the individual case, the hospital career of each patient was plotted on charts. The number of days spent in the hospital, number of days spent out of the hospital* (counting only absences of 14 days or longer) and the number of moves into the hospital, counting the first admission as a move, were computed for the first two years of hospitalization, the first three years and the first four years. Each of these factors was related to outcome at the end of two years, five years, eight years and 13 years following first admission—and to outcome as of April 1, 1952.

An examination of the indices based on the first two years, three years and four years following first admission, indicated that the index based on the first two years was most useful, because, after that period, the bulk of the ultimately discharged patients were out of the hospital, and the index for the discharged patients does not change very much after discharge.

An analysis of these figures indicated that there were certain critical points in the distribution of duration of hospital residence and duration of visits which were crucial to eventual outcome. These critical points were as follows: (1) for duration of hospital residence—600 days; (2) for duration of visits—no visits and 100 days of visit. A tabulation was made for each follow-up period of these two factors—duration of residence and duration of visits—divided at the critical points. The data for the 13-year follow-up

*The number of days spent out of the hospital for the patients who were still hospitalized at the expiration of the first two years from their first admission (the in-patients) was determined by counting the actual number of days out of the hospital during the first two years of hospitalization. For the patients who were *discharged* during the first two years, the number of days out of the hospital was calculated up to the date when they left the hospital for the last time during the period of two years following their first admission.

showed the greatest differential between the "in's" and the "out's" and these data are shown in Table 4.

Table 4. Outcome on 13-year Follow-up by Number of Days In and Number of Days Out of the Hospital During the First Two Years Following First Admission

	Continuous hospitalization		Out less than 100 days		Out more than 100 days		Totals		
Days in	In	Out	In	Out	In	Out	In	Out	Combined
1-49	0	10					0	10	10
50-99	3	13				1	3	14	17
100-149	3	15		1		2	3	18	21
150-199	4	13		1	2	2	6	16	22
200-249	0	12			3	3	3	15	18
250-299	2	4		2	1	4	3	10	13
300-349	2	4	1	4	1	2	4	10	14
350-399	1	6		1			1	7	8
400-449	1	1			1	1	2	2	4
450-499	2	1				2	2	3	5
500-549	1	2		1			1	3	4
550-599	0	3			2		2	3	5
Total	19	84	1	10	10	17	30	111	141
600-649		1		1	3		3	2	5
650-699	1	1	3	1			4	2	6
700-749	38	9		1			38	10	48
Total	39	11	3	3	3	0	45	14	59
Grand total	58	95	4	13	13	17	75	125	200

To summarize the trends shown in Table 4, the results were combined in accordance with the critical points discovered in the analyses of the data in that table, and are presented in Table 5.

In this table, the data are tabulated in accordance with the critical duration of hospitalization of 600 days or more, and in accordance with the duration of absence from the hospital of 100 days or more. For each combination the rate of improvement (percentage of patients out of the hospital at the end of the 13-year follow-up) is shown.

In general 63 per cent of the entire group of patients were found to be out of the hospital at the time of the 13-year follow-up. A higher proportion, 79 per cent, of those who had lived in the hospital less than 600 days of their first two years following first admission, were out of the hospital, while, of those who had remained in residence 600 days or more during the first two years following

Table 5. Outcome* on 13-year Follow-up in Accordance with Number of Days of Actual Hospital Residence During First Two Years Following First Admission, and by number of days on visit** from hospital during that period

	Duration of Residence										
	Less than 600 days			600 days +			Total				
Duration of visits (days)	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	X^2	P
None	19	84	82.	39	11	22.	58	95	62.	48.22	<.01
Less than 100	1	10	90.	3	3	50.	4	13	77.	0.20	>.05
More than 99 days	10	17	63.	3	0	0.	13	17	57.	2.98	>.05
Total	30	111	79.	45	14	24.	75	125	63.	51.35	<.01

*Outcome is evaluated in terms of being found either in the *hospital* or *outside of the hospital* on follow-up.

**A visit is defined as an absence from the hospital lasting a fortnight or more.

admission, only 24 per cent were out of the hospital. The total time spent out of the hospital during visits seemed to be differential only in the first group—those who were in the hospital less than 600 days. In their case, patients with no visits, or with less than 100 days of visits, had a larger proportion out of the hospital than those whose durations of visits exceeded 100 days. Why there should be this negative relation between outcome and duration of visit in this range remains a question requiring further investigation.

The bulk of the patients stayed in the hospital less than 600 days and were continuously in the hospital for their periods of stay. Their improvement rate was 82 per cent, while those who remained continuously in the hospital for more than 600 days during their first two years of hospitalization showed an improvement rate of only 22 per cent.

Summarizing the chance for eventual improvement in the light of these findings, it is found that the group with the best prognosis is the one which stays in the hospital less than 600 days and which is absent for some period, but not exceeding a total of 100 days, during residence. Their expected improvement rate is 10 out of 11 or 90 per cent. Next in order of good prognosis are the patients who remained continuously in the hospital less than 600 days. The improvement rate for them is 84 in 103, or 82 per cent. Third in order of good prognosis is the group which remained in the hospital less than 600 days and which was absent more than 100 days

during that period. For this group, the improvement rate is 17 out of 27, or 63 per cent.* The group which stayed in residence longer than 600 days during the first two years of their hospital careers, showed an average improvement rate of only 24 per cent and was composed chiefly of patients who were continuously in the hospital during their residences with no visits.

The comparable data for each of the follow-up periods are shown in Table 6 and Figure 2.

It will be noted that the over-all improvement rate was rather constant, dropping only slightly from 67 and 68 per cent for the immediate (two-year) and five-year follow-ups respectively to 63 per cent for the 13-year follow-up.

For the group with less than 600 days of residence, the improvement rates dropped from 92 per cent for immediate outcome at two years to 79 and 80 per cent for the 13-year and final follow-ups (as of April 1, 1952) respectively.

For the group with more than 600 days of residence, the improvement rates were rather low, 9 per cent on immediate outcome, but they were stabilized at 24 and 25 per cent beginning with the five-year follow-up period.

Regarding the duration of visits, the group with medium durations (less than 100 days, but not zero) ranged in improvement from 65 per cent immediate to 70 per cent at the eight-year follow-up, and then rose to 77 per cent and maintained that level. It remained superior in outcome for each follow-up period to the group that showed more than 100 days of visit and also, finally, to the group that remained continuously in residence up to discharge during the first two years and had no home visits.

Since the number of moves also entered into the construction of the mobility index, it is important to determine the influence of the number of moves on outcome. Table 7 shows the number of moves by duration of hospitalization and by total duration of visits for the 13-year follow-up.

*A statistical evaluation of the significance of these trends indicated that the number of patients who were in the hospital less than 600 days during their first two years of hospitalization and who were on visit for more than 100 days during this period, had a significantly larger proportion in the "in" group on follow-up (10 was the number observed and 5.74 was the "number expected" in the group). Why the patients who showed the excessive mobility should have a poorer outcome remains an interesting question.

Table 6. Outcome on 2, 5, 8 and 13-year Follow-ups, and as of April 1, 1952, by Number of Days of Actual Hospital Residence During First Two Years Following First Admission and by Number of Days on Visit During That Year

<600 Days in the Hospital

Follow-up Periods

Group	2 years			5 years			8 years			13 years			4/1/52		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
No movement	0	103	100.	8	95	92.	13	90	87.	19	84	81.	17	86	84.
<100 days	0	11	100.	1	10	90.	1	10	90.	1	10	90.	1	10	90.
100 days+	12	15	56.	10	17	63.	14	13	48.	10	17	63.	10	17	63.
Total	12	129	92.	19	122	87.	28	113	80.	30	111	79.	28	113	80.

600 Days or More in the Hospital

Follow-up Periods

Group	2 years			5 years			8 years			13 years			4/1/52		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
No movement	46	4	8.	39	11	22.	36	14	28.	39	11	22.	38	12	24.
<100 days	6	0	0.	4	2	33.	5	1	17.	3	3	50.	3	3	50.
100 days+	2	1	33.	2	1	33.	3	0	0.	3	0	0.	3	0	0.
Total	54	5	9.	45	14	24.	44	15	25.	45	14	24.	44	15	25.

Total

Group	2 years			5 years			8 years			13 years			4/1/52		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
No movement	46	107	70.	47	106	69.	49	104	68.	58	95	62.	55	98	64.
<100 days	6	11	65.	5	12	70.	6	11	65.	4	13	77.	4	13	77.
100 days+	14	16	53.	12	18	60.	17	13	43.	13	17	57.	13	17	57.
Total	66	134	67.	64	136	68.	72	128	64.	75	125	63.	72	128	64.

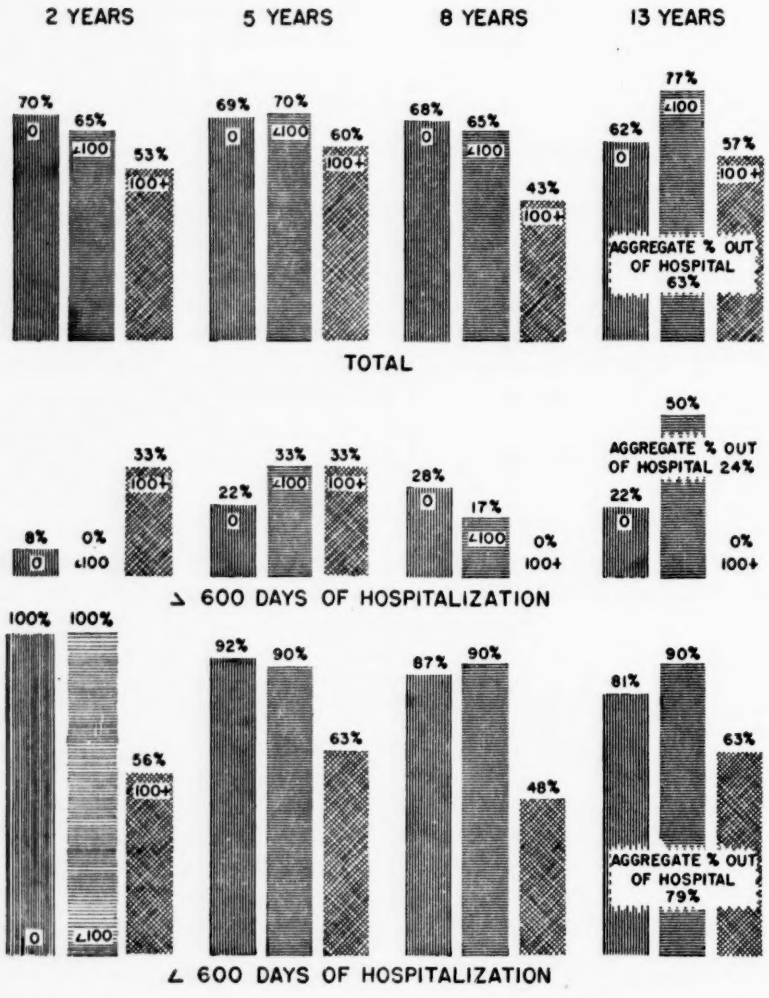

Figure 2. Percentages of patients out of hospital two, five, eight and 13 years after admission, arranged according to number of days spent out of hospital (none, less than or more than 100) during first two years after admission. It will be observed, upper line, that while those patients who spent less than 100 days out of the hospital had better long-term prognoses this is not a particularly sensitive measure. More selective are distinctions devised by dividing the group into two parts—those patients who spent 600 days or more in the hospital (second line) and those who spent less than that time (third). In both instances the components of these groups are further arranged on the basis of the amount of time they were in the hospital

The improvement rates for those who were continuously in the hospital, for those who had one move, and for those who had more than one move, are approximately the same—62 per cent and 70 per cent—which is not very different from the improvement rate for the entire group, 63 per cent, regardless of the number of moves they made. Consequently, the number of moves *per se* is not related to the outcome in individuals like those studied here. This is in clear contrast with the improvement rates figured on the basis of length of stay in the hospital, which drop from 81 per cent for those in the hospital less than 400 days to 61 per cent and 24 per cent for durations of 400 to 599 days and 600 to 730 days respectively.

Since the 13-year follow-up was found to give the most representative picture of the outcome, determined for the shorter as well as the longer follow-up periods, the discussion will be limited to this follow-up period, and the influence of the background factors such as sex, age, diagnosis, and total number of moves (regardless of their duration) will be investigated. The data for sex are presented in Table 8.

For the entire group of 200 patients, the males and females did not differ significantly in improvement rates. In the group hospitalized for less than 600 days, the males had somewhat higher improvement rates than the females. This differential was especially marked in the group with more than 100 days of visits, but it was not statistically significant.

The data for age are shown in Table 9. When the entire group of 200 patients is considered, no consistent relationship of improvement with age emerges. For the group hospitalized less than 600 days, the older patients—those who became first admissions in their fifth decades of life—tended to have the higher improvement

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(0 — no time out), (< — less than 100 days out), (> — more than 100 days out) and whether they were in or out of the hospital at the end of two, five, eight and 13 years after the date of admission.

It will be observed that of those patients admitted to the hospital during 1939, who were alive 13 years later, 63 per cent were out of the hospital. If they had spent less than 600 days in the hospital in the first two years they had a 3:1 chance of being out as contrasted with those who spent more than 600 days in the hospital during the first two years. Furthermore, in both these groups, those patients who spent some but not the greatest amount of time out of the hospital during their period of hospitalization had a distinctly better chance of being out of the hospital later on than the rest of their respective groups.

Table 7. Number of Absences from the Hospital in Relation to Outcome on 13-year Follow-up, by Duration of Hospital Residence During First Two Years Following First Admissions, and by Duration of Visits During That Period

Number of absences	Duration of absences (days)	Days of hospital residence: 1-399 In	1-399 Out	1-399 Per cent out	400-599 In	400-599 Out	400-599 Per cent out	600-730 In	600-730 Out	600-730 Per cent out	Total In	Total Out	Total Per cent out
0	0	15	77	83.7	4	7	63.6	39	11	22.0	58	95	62.1
1	<100	1	8	88.9	0	1	..	2	2	50.0	3	11	78.6
1	>100	6	11	64.7	3	1	25.0	2	0	0.0	11	12	52.2
Total		7	19	73.1	3	2	40.0	4	2	33.3	14	23	62.2
>1	<100	0	1	..	0	0	..	1	1	..	1	2	66.7
>1	>100	1	3	75.0	0	2	..	1	0	..	2	5	71.4
Total		**1**	**4**	**80.0**	**0**	**2**	..	**2**	**1**	33.3	3	7	70.0
Grand total		23	100	81.3	7	11	61.1	45	14	23.7	75	125	63.0

Table 8. Sex in Relation to Outcome on 13-year Follow-up by Duration of Hospital Residence During First Two Years Following First Admission and by Duration of Visits During That Period

Less Than 600 *Days of Hospital Residence*

	No visits			Visits 100 days			Visits 100 days +			Total		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
Males	7	35	83.3	1	6	85.7	3	8	72.7	11	49	81.7
Females	12	49	80.3	0	4	100.0	7	9	56.3	19	62	76.5
Total	19	84	81.6	1	10	90.9	10	17	63.0	30	111	78.7

More Than 600 *Days of Hospital Residence*

	No visits			Visits 100 days			Visits 100 days +			Total		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
Males	18	7	28.0	2	0	0.0	2	0	0.0	22	7	24.1
Females	21	4	16.0	1	3	75.0	1	0	0.0	23	7	23.3
Total	39	11	22.0	3	3	50.0	3	0	0.0	45	14	23.7

Total

	No visits			Visits 100 days			Visits 100 days +			Total		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
Males	25	42	62.7	3	6	66.7	5	8	61.5	33	56	62.9
Females	33	53	61.6	1	7	87.5	8	9	52.9	42	69	62.2
Total	58	95	62.1	4	13	76.5	13	17	56.7	75	125	62.5

Table 9. Age in Relation to Outcome on 13-year Follow-up by Duration of Hospital Residence During First Two Years Following First Admission and by Duration of Visits During That Period

Age	No visits			Visits < 100 days			Visits 100 days +			Total		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
Less Than 600 Days of Hospital Residence												
15.5-20.4	3	7	70.0	0	0	..	0	1	..	3	8	72.7
20.5-25.4	4	19	82.6	0	3	..	3	4	57.1	7	26	78.8
25.5-30.4	6	11	64.7	0	3	..	1	2	66.7	7	16	69.6
30.5-35.4	3	17	85.0	0	1	..	1	6	85.7	4	24	85.7
35.5-40.4	1	11	91.7	1	0	..	5	0	0.0	7	11	61.1
40.5-45.4	1	12	92.3	0	2	..	0	2	..	1	16	84.1
45.5-50.4	1	7	92.0	0	1	..	0	2	..	1	10	90.9
Total	19	84	81.6	1	10	90.9	10	17	63.0	30	111	78.7
More Than 600 Days of Hospital Residence												
15.5-20.4	2	1	33.3	0	0	..	0	0	..	2	1	33.3
20.5-25.4	3	1	25.0	1	1	50.0	1	0	..	5	2	28.6
25.5-30.4	10	2	16.7	1	0	..	0	0	..	11	2	15.4
30.5-35.4	7	2	22.2	0	0	..	0	0	..	7	2	22.2
35.5-40.4	8	3	27.3	0	1	..	1	0	..	9	4	30.8
40.5-45.4	5	1	16.7	1	0	..	1	0	..	7	1	12.5
45.5-50.4	4	1	20.0	0	1	..	0	0	..	4	2	33.3
Total	39	11	22.0	3	3	50.0	3	0	..	45	14	23.7
Total												
15.5-20.4	5	8	61.5	0	0	..	0	1	..	5	9	64.3
20.5-25.4	7	20	74.1	1	4	80.0	4	4	50.0	12	28	70.0
25.5-30.4	16	13	44.8	1	3	75.0	1	2	66.7	18	18	50.0
30.5-35.4	10	19	65.5	0	1	..	1	6	85.7	11	26	70.3
35.5-40.4	9	14	60.9	1	1	..	6	0	..	16	15	48.4
40.5-45.4	6	13	68.4	1	2	66.7	1	2	66.7	8	17	68.0
45.5-50.4	5	8	61.5	0	2	..	0	2	..	5	12	70.6
Total	58	95	62.1	4	13	76.5	13	17	56.7	75	125	62.5

rates. Before concluding that the older first admissions tend to have a better outcome, it should be remembered that the total number of survivors in the discharged group is not known exactly, while the number of survivors in the still hospitalized group is known precisely. Perhaps the excess of patients in the improved group is attributable to the fact that the dead are being counted as well as the living in this group, while only the living are counted in the undischarged group. This becomes especially important since death, no doubt, took its toll from the older discharged group, but not all these deaths were reported to the hospital.

The data for the different diagnoses are shown in Table 10.

For the group as a whole, the manic-depressive patients and the involutional melancholia patients showed the highest improvement rate. It is interesting to note, however, that the dementia præcox group also showed a rather high improvement rate for the patients who remained in the hospital less than 600 days but who went on visit for a total of less than 100 days. Similarly, the patients diagnosed with paranoid condition, showed a rather high improvment rate for those who remained in the hospital less than 600 days but showed no movement.

In Table 11 the total number of absences from the hospital is related to outcome. It will be recalled that the number of moves or visits were counted by enumerating the number of returns from an absence from the hospital lasting at least a fortnight. It was thought that moves of this minimum duration would represent actual changes in mental status more closely than moves of shorter duration, but the previous analysis has cast some doubt on this hypothesis. To probe more deeply into the question of patient mobility, the actual numbers of absences during the first two years of hospital life were determined regardless of duration. To keep this item in harmony with the number of moves, the number of such absences was determined by counting the number of returns from absence regardless of the duration of the absence. The first admission to the hospital was counted as one return from the outside in order to prevent the number of returns from dropping to zero.

The patients who had three or more returns from absence showed the highest rate of improvement, and this was especially marked in the group that lived in the hospital less than 600 days. There were 21 such patients, 20 of whom were found to be out of the hospital on follow-up (95 per cent). The patients with hospital

Table 10. Diagnosis in Relation to Outcome on 13-year Follow-up by Duration of Hospital Residence During First Two Years Following First Admission and by Duration of Visits During That Period

Diagnosis	No visits			Visits <100 days			Visits 100 days+			Total		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
Less Than 600 Days of Hospital Residence												
Manic-depression	4	37	90.2	0	5	100.0	1	8	88.9	5	50	90.9
Dementia præcox	14	29	67.4	1	4	80.0	7	6	46.2	22	39	63.9
Involutional melancholia	0	10	100.0	0	1	..	0	2	100.0	0	13	100.0
Paranoid condition	1	7	87.5	0	0	..	2	0	0.0	3	7	70.0
Undiagnosed	0	1	..	0	0	..	0	1	..	0	2	100.0
Total	19	84	81.6	1	10	90.0	10	17	63.0	30	111	78.7
More Than 600 Days of Hospital Residence												
Manic-depression	0	2	100.0	0	0	..	0	0	..	0	2	100.0
Dementia præcox	34	7	17.0	2	3	60.0	2	0	0.0	38	10	20.8
Involutonal melancholia	1	1	50.0	1	0	..	0	0	..	2	1	33.3
Paranoid condition	4	0	0.0	0	0	..	1	0	..	5	0	0.0
Undiagnosed	0	1	..	0	0	..	0	0	..	0	1	..
Total	39	11	22.0	3	3	60.0	3	0	..	45	14	23.7
Total												
Manic-depression	4	39	84.6	0	5	100.0	1	8	88.9	5	52	91.2
Dementia præcox	48	36	42.9	3	7	70.0	9	6	40.0	60	49	45.0
Involutional melancholia	1	11	91.7	1	1	50.0	0	2	100.0	2	14	87.5
Paranoid condition	5	7	63.6	0	0	..	3	0	0.0	8	7	46.7
Undiagnosed	0	2	100.0	0	0	..	0	1	..	0	3	100.0
Total	58	95	62.1	4	13	76.5	13	17	56.7	75	125	62.5

Table 11. Number of Returns from Absence* in Relation to Outcome on 13-year Follow-up by Duration of Hospital Residence During First Two Years Following First Admission and by Duration of Visits During That Period

Number of returns from absence*	No visits**			Visits 100 days			Visits 100 days+			Total		
	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out	In	Out	Per cent out
Less Than 600 Days of Hospital Residence												
1+2	19	78	80.4	1	3	75.0	9	10	52.6	29	91	75.8
3+	0	6	100.0	0	7	100.0	1	7	87.5	1	20	95.2
Total	19	84	81.6	1	10	90.9	10	17	63.0	30	111	78.7
More Than 600 Days of Hospital Residence												
1+2	39	11	22.0	0	2	100.0	1	0	..	40	13	24.5
3+	..	..	..	3	1	25.0	2	0	0.0	5	1	16.7
Total	39	11	22.0	3	3	50.0	3	0	45.0	45	14	23.7
Total												
1+2	58	89	60.5	1	5	83.3	10	10	50.0	69	104	60.1
3+	0	6	100.0	3	8	72.7	3	7	70.0	6	21	77.8
Total	58	95	62.1	4	13	76.5	13	17	56.7	75	125	62.5

*A return from absence is defined as a return from outside the hospital regardless of whether a 14-day visit preceded the return. The first move into the hospital at the time of first admission also counts as a "return from absence."

**No absence longer than 14 days.

residences exceeding 600 days did not show consistent relationships between outcome and number of returns from absence.

Summarizing the relationship between background variables and outcome, it appears that males, over 40 at time of first admission whose diagnosis was either manic-depressive psychosis or involutional melancholia and who exhibited a considerable amount of mobility (more than one return to the hospital after their first admissions), would tend to have the best chance of being out of the hospital on follow-up. But the chances of improvement for patients not belonging to this highly-selected category were also high in many instances and these can also be found from perusing the tables.

The major difficulty in making any inferences from the immobility index is the absence of information on the number of discharged patients who survived during each follow-up period. Since only those cases in the "in" group who were known to be alive as of the day of follow-up were included in the sample, it may be argued that the reason for the favorable outcome in cases of patients with high mobility indices is attributable to the fact that the discharged group contained many persons who were no longer alive on the day of the survey. To investigate the survival rate of discharged patients, a letter was sent to each discharged patient in which he was asked to take part in a statistical survey of population mobility and to indicate on an enclosed card whether he still lived at the address to which the letter was directed.

There was room on the card to indicate whether the addressee was deceased or moved; and in the latter case, his new address was asked for. Of the 127 discharged patients, the whereabouts of 45 were determined in this way. Of the remaining 82, 40 failed to return the card; and for 42, the postoffice returned the card as "not found," "unknown" or "unclaimed." In order to determine the survival rate of this unresponsive group, 10 names (12 per cent sample of the 82) were taken at random, and these patients were visited by social workers. All 10 were found to be alive and out of the hospital.*

Of the 45 patients for whom cards were returned, five, or 11 per cent, were found to have died. The proportion of dead among

*These cases apparently all belonged to a type who, having made borderline adaptations to extramural existence, are rendered uneasy about references to their former hospital stay.

those who failed to answer is probably no greater, and is, in fact, probably smaller since not a single death was found in the random 12 per cent sample of 10 patients who were visited. It would seem, therefore, safe to conclude that the discharged patients in this study are for the most part comparable with the still undischarged as far as survival is concerned. Whatever error the 11 per cent of deceased patients may introduce into the comparison of discharged and undischarged patients can be neglected.

Discussion

The utility of the immobility index in predicting outcome of mental illness seems to rest on three factors in the following relative order of importance: (1) the duration of actual hospital residence during the two years following first admission; (2) the total duration of absences and (3) the number of actual absences from the hospital. The patients whose hospital residences during the first two years are less than 600 days seem to have the better prognoses. This fact comes as no surprise, since most of these patients are in the early stages of illness, and the outlook for early cases is generally better than for chronic cases. The relationship between outcome and duration of residence during the first two years is even more strikingly borne out in Table 7, where the breakdown is made into 1-400, 400-600 and 600-730 days.

The improvement rates for these three groups (percentages out of the hospital at the end of 13 years) are: 81.3, 61.1 and 23.7, indicating that outcome on 13-year follow-up is directly proportional to duration of residence during the first two years of hospitalization.

But within the presumably non-chronic group of cases, patients who were on visit longer than 100 days did not have such good outcomes as those who accumulated less than 100 days of visit. Why this should be so is somewhat puzzling.

Perhaps the key to this paradox is found in the relationship between number of absences from the hospital and outcome. Those who visit at home three or more times during their first two years of hospitalization, regardless of the length of the visits, seem to fare better than those whose visits are fewer. Perhaps only the number of moves (disregarding duration) rather than the duration of moves is the differential.

The invariancy of the outcomes during the five-year, eight-year, 13-year and 19-year (for readmissions) follow-ups is very striking. Apparently the outcome on each of these follow-up periods for those whose initial hospitalization lasted less than 600 days was in the neighborhood of 80 per cent out of the hospital, and varied but little from this figure, while the outcome for those who were hospitalized longer than 600 days was almost exactly 25 per cent, with almost no variation from year to year. It may be concluded that one of the best bases for predicting the fate of a hospitalized patient five, eight, 13 and 19 years later (if he survives that long) is the duration (in days) of his first period of hospitalization. Such a prognosis is of little help at the time of first admission, but can be of considerable help in the case of readmissions and can be of extreme help in establishing equivalent groups for experimental purposes. Furthermore, a biometric investigation, with psychological, physiological, anatomical, biochemical, psychiatric and other techniques, of patients who are released during the first three, six, nine, 12, 15 and 18 months following their first hospitalizations can perhaps yield patterns of functioning which may identify those who are eventually going to have chronic ailments from those who will probably be relieved of illness at an early period.

Summary

One of the neglected factors in predicting the eventual outcome of hospitalized mental disorders is the history of the patient's career during his first few years of hospital life. A special feature of the early hospital career of mental patients is the degree of mobility or stagnation they exhibit, that is, the number of visits which they make to their homes. A previous study by the Columbia Greystone Associates developed an index relating the number of months of hospitalization to the number of moves made out of the hospital. This is the "occlusive" index. This index was found to be related negatively to the improvement rate for groups, but it was not suitable for individual prognosis.

To examine the relationship between the degree of mobility of the individual patient and the eventual outcome of his illness, the early hospital careers of first admissions and readmissions to the New Jersey State Hospital at Greystone Park were examined, and "immobility indices" were computed for the first year, the first two

years, the first three years, and the first four years of hospitalization, and these were related to immediate outcome (at the end of the prognostic base period) to five-year follow-up, eight-year follow-up, 13-year follow-up and status as of April 1, 1952. The immobility index, based on the first two years of hospitalization, was computed by dividing the total months of residence during the first two years by the number of returns from visits lasting at least a fortnight. The first move into the hospital, at the time of first admission, was also counted as a move.

The results indicated that the immobility indices for the patients who were found to be in the hospital at the end of each of the follow-up periods tended to be about twice as large as those which characterized the out-patients. This confirmed the general relationship noted by the Columbia Greystone Associates.

A further examination of the factors underlying this index: the duration in months of hospitalization; the duration of visits (a visit being defined as absence from the hospital for longer than a fortnight); and the number of visits indicated that the duration of hospitalization showed the closest relationship to outcome. Patients who stayed in the hospital less than 600 days showed the highest improvement rate. Next in order of importance was the total duration of visits. Patients continuously in the hospital without any visit and those whose visits totaled more than 100 days, tended to have lower improvement rates than those who were out on visit less than 100 days. The number of visits alone bore no relationship to outcome.

The number of returns from absences from the hospital, regardless of duration of absence, was found to be positively related to outcome. Patients who had been away from the hospital more than two periods (lasting from overnight to longer periods) during their first two years of hospitalization tended to have considerably higher improvement rates.

In considering these results, it must be borne in mind that the improvement rate calculated in this study was based on the number of patients who survived from 13 years after their first admissions to the hospital in 1939 (or after their readmissions in that year in the case of 52 readmissions). There is no guarantee that all the discharged patients not known to be dead were alive at the time of follow-up selected for this study.

Accordingly a follow-up by mail was undertaken in the guise of a statistical study of population shifts, in which each of the discharged patients received a letter asking him to indicate on the enclosed card whether he still lived at the same address to which the letter was addressed. Information was obtained in this manner on 45 former patients in the discharged group, constituting one-third of the total number of discharged patients in this study. In this group an 11 per cent mortality rate was noted. The remaining two-thirds from whom no reply was received were sampled, and social workers visited the 10 per cent random sample. Not a single death was found in this group. It may be concluded, therefore, that the results reported in this study suffer from no more than a 10 per cent error insofar as about 10 per cent of the discharged patients did not survive to the end of the survey period, while the entire group of still hospitalized patients in the survey were alive. That this small margin of error would cause any drastic changes in the results is hardly likely.

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THE PSYCHOLOGIC IMPLICATIONS OF OVEREATING

BY STANLEY W. CONRAD, M. D.

Obesity is one of the more serious health problems of our times. It is the most frequent physical abnormality, for at least one-fifth of the population over the age of 30, or about 15,000,000 persons, are 10 per cent or more overweight.[1] Obesity exerts an adverse influence on many physical illnesses such as diabetes, the cardiovascular diseases, nephritis, the toxemias of pregnancy, and degenerative arthritis. Where obesity is present there is an increase in the incidence of gall bladder disease, hypertension and diabetes. Newburgh[2] found that an increase in mortality rate is proportional to pounds overweight. He states: "Between the ages of 45 and 55, twenty-five pounds of excess weight means a 25 per cent greater chance of dying within the next year; 50 pounds of overweight means that you have a 50 per cent greater chance of death in the next year than a person of normal weight." Furthermore, obesity seriously affects the emotional life of its victims. They usually feel self-conscious, sensitive, inferior, and different. Thus they tend to avoid people and withdraw into a state of inactivity which further increases their obesity.

Obesity results when the food intake exceeds over a period of time the energy requirements of the body. In other words, obesity is a direct result of overeating. When the food intake is decreased there will be a commensurate loss in weight. Although obesity is a reversible condition, treatment generally has not been too successful. Any weight loss resulting from the common methods of treatment—such as by dieting and anorexigenic drugs—is not usually sustained. Fellows[3] reported that 81 per cent of 294 individuals under treatment which relied in most cases on diet alone lost weight, but 19 per cent failed to lose. One year later, 32 per cent of the 224 patients available for examination showed further loss, but 68 per cent had gained. Five years later, 21 per cent of 193 cases available for examination continued to show weight loss, but 79 per cent had gained. In a recent extensive survey[4] only 16 per cent of all people who made an attempt to lose weight by dieting claimed any success. Moreover, more than one-half of this group regained their weight as soon as they stopped their diets.

Overeating is a symptom, therefore the successful control of it depends on the removal of its causes. What are the causes of

overeating? It has been shown experimentally that damage to certain nuclei of the hypothalamus will produce a marked increase in food consumption.[5] It is believed that diseases in humans which damage the hypothalamus, like encephalitis, will result in overeating. These cases, however, are very rare. Overeating may, in certain instances, be a habitual practice of some families or even certain groups of people. In Pennsylvania Dutch families, for example, each meal is a feast consisting of a tremendous quantity of food. All other cases of overeating almost invariably are associated with a disturbance in the emotional life of the obese person. Restriction in food intake by dieting and drugs is usually incapable of stemming the urge to eat, arising from the emotions. This accounts for the difficulty most people have—as in the foregoing studies—of staying on a reducing diet, and accounts for the return of weight once the enforced dietary restrictions have been removed.

Except for the foregoing isolated cases, overeating implies the existence of some emotional problem. An understanding of the implications of overeating will help in the understanding and treatment of the patient's emotional problem, which if successful, will result in the cessation of overeating. The implications of overeating can be divided into three main categories: (1) anxiety, (2) gratification and (3) hostility. (These are the most important causes for overeating. An additional cause, which is associated with the secondary gains of obesity itself, will be the subject of another paper.)

Anxiety

The person who has a propensity to overeat is orally fixated. Whenever he develops anxiety, he regresses to the oral level—that is, he resorts to food in an attempt to allay this anxiety. Anxiety may be the result of any situation, internal or external, which threatens the organism. External stressful events such as entry into school, a new marriage, an operation, a new job, death of a close relative, may precipitate overeating. There are reports in the literature of cases of obesity that developed immediately following some harrowing experience during the last war.[6,7] Feelings of insecurity are common personality characteristics of the obese person. This insecurity keeps him in an almost constant state of anxiety. The obese person is also very sensitive and easily hurt by trivialities. In response to this hurt, he develops hostility. Be-

cause of his fear of retaliation and disapproval, he is unable to express his hostility and thus must repress it. This, too, results in anxiety. (The role of hostility in overeating will be further discussed under the category "Hostility.") Conflicts, neurotic fears, and guilt are some other internal situations which create anxiety and result in overeating.

The person who resorts to food to allay anxiety will eat whenever he experiences tension. He is unconsciously aware that food tends to offer him a temporary respite from his unpleasant state of tension. Food is almost like a narcotic to the obese person—in fact, the overeating of the obese has often been compared to drug addiction. The obese person seeks in food an escape from the unbearable stresses of life. One obese patient compared eating to "the joy of drowning."

The patterns of eating vary. For example, there are some who eat almost incessantly in their attempts to relieve a constant state of tension. This pattern is often found in obese housewives who nibble throughout the day, and in others to whom food is easily accessible. They complain of a persistent hungry feeling described by some as a "gnawing" sensation in the epigastrium. There are others who eat whenever they are confronted with situations which engender anxiety in them. These situations may be normally very trivial. One patient, for example, would overeat for several days prior to the arrival of invited guests. Another would indulge in a large chocolate bar just before attending a P'TA meeting.

Just as the drug addict depends on his drug, and the alcoholic on his alcohol, so the obese person grows to depend on food. There are no actual withdrawal symptoms, but many report a panicky feeling whenever food is not readily accessible to them. This is one of the main reasons why fat people are either reluctant to go on a diet or unable to stay on one; their dependence on food to relieve anxiety is so great that they fear the thought of deprivation. In addition, they are aware from past experiences, how irritable they become when they start dieting; for without food they cannot narcotize their anxiety, but instead react to it with fight. This fight reaction is strange and unacceptable to the usually docile ego of the obese.

The question arises: Why does the obese person resort to food to relieve anxiety? Bychowski[8] believes that overeating is an attempt to allay anxiety by orally incorporating, and thus identify-

ing with, mother. He says: "The soothing effect of food as a powerful remedy for frustration and anxiety reveals that its symbolic implication is that of love, predominantly maternal love and breasts as the first distinct objects of desire and gratification. Accordingly compulsive eating occurs as a direct result of separation anxiety in its various forms and at various levels. . . . The first unconscious implication of compulsive overeating is the securing of mother in the most primitive but also the most efficient and complete form—introjection, that is cannibalistic incorporation."

In a previous communication[9] it was hypothesized that eating to relieve anxiety in the adult has its origin in the effect that food had on the infant. Probably the first discomfort that the infant experiences is hunger. Food offers a gratifying relief. But it is also observable that food can soothe the tension in the infant due to other anxiety-producing situations such as loneliness, darkness, pain, frustration, etc. In other words, the infant cannot distinguish between the causes of his anxiety and is able to find in food a relief of his tension resulting from any cause, just as he was able initially to relieve the tension resulting from hunger. The obese adult is orally fixated and thus resorts to the same methods to relieve his anxiety as the infant in his oral stage of development.

Food may represent security to the obese individual. This representation also had its origin in childhood. Obese adults usually come from a familial environment that offered them little emotional security.[10] They were rejected by their parents, and food was offered as a substitute for love. In these families, food "had been charged with a high emotional value and stood for love, security and satisfaction and represented in all instances an important tie in the relationship between parents and children."[11] Overeating and obesity alleviated the obese child's feelings of insecurity and insignificance. Likewise, food bolsters security in the adult, and he will overeat whenever he feels insecure. This is similar to the acquisition of material things—like going on a shopping spree—in an unconscious effort to acquire security.

A young woman of 28 portrayed this pattern strikingly. During her analysis, she frequently indulged in bouts of overeating and simultaneous shopping sprees. One of these episodes occurred immediately after she was discharged from her job. She began to eat—even though for several weeks prior to this event she had been successfully dieting and losing weight. In addition, she bought five new, expensive dresses, notwithstand-

ing her precarious financial status. Overeating, as well as her shopping, was an attempt to gain security and alleviate her anxiety.

It is often observed that obese individuals are found in poor families. This seemingly paradoxical situation was frequently encountered during the depression years. This is partly due to the fact that carbohydrate foods are the least expensive and are the main fare of poor families. More significantly, however, food in these families assumes an exaggerated importance, and overeating is an attempt to alleviate the anxiety resulting from their financial insecurity.

Bruch[10] makes reference to Falstaff, Shakespeare's fat man, who says: "If I do grow great, I'll grow less." (King Henry IV, Part I, Act V, Scene IV.) In non-poetic language, he is saying: "If I gain security through acquisition, power and prestige, then I shall have no further need to resort to overeating."

Not any kind of food is used to relieve anxiety. Carrots and celery would be completely ineffectual. The obese person indulges in food high in carbohydrate content—like candy, cookies, ice cream, etc.—for only with these foods can he temporarily narcotize his anxiety. During his spells of anxiety, he develops an intense craving for sweets. Each individual usually has his own favorite carbohydrate concoction—a specific cookie, a chocolate bar, a dish of ice cream—but substitutes are effective, provided that their carbohydrate content is high. It requires extreme effort and willpower for the obese to resist giving in to this longing for sweets. Patients tell of the conflicts they have, once they begin to develop through treatment more ego-strength and an earnest desire to reduce. Whereas formerly they automatically, and almost unconsciously, indulged in sweets whenever they were beset with anxiety, now they are aware of this propensity and must exert tremendous efforts to fight against it. Sometimes they fail and give in to their longings. They then feel ashamed and discouraged. If, however, they are successful in warding off the longings, they feel proud of themselves and are eager to tell of their success, either to the therapist or to the group therapy members.

The questions naturally arise: How and why do sweets alleviate anxiety? They surely don't have the narcotizing properties of alcohol or morphine. Is it possible that there may be a physiological need for sweets? Portis, et al.[12] found a functional hyperinsulinism and lowered carbohydrate level in individuals subject to stress.

However, the possible existence of a lowered blood sugar level resulting from stress, probably has little if anything to do with the intense craving for sweets, since this craving may occur with a normal or even above-normal blood sugar. Many patients, in fact, may develop an intense yearning for sweets shortly after a heavy meal. Moreover, hyperglycemia is observed more frequently in the obese than hypoglycemia, and, furthermore, obesity is not a frequent symptom in functional hypoglycemia.

We shall probably never have the complete answer unless somehow it becomes possible to explore the sensation which the infant experiences as he suckles. If mother's milk or bottle milk is considered sweet by the suckling, then it is more readily understandable why orally fixated individuals resort to sweets during anxiety. It is a return to the soothing comfort and protection of mother's breast. Most obese people characteristically have a marked dependence on their mother or some mother figure. Some patients reveal during treatment an unconscious association between sweets and the breasts. One young patient, whenever she experienced anxiety, would get into bed and nibble on a large chocolate bar. Another patient, during moments of anxiety would eat chocolate-chip cookies and drink milk. These activities represented to their unconscious the sensation of sucking at mother's breast.

Gratification

Recently a cartoon in one of the daily newspapers, depicted two women sitting at a restaurant table. One was talking: "Do I have a mink coat? No! Do I have a man with money? No! So I should deny myself another piece of cream pie?" This cartoon neatly illustrates the self-indulgent and self-gratifying attitude of the overeater, and the value he places on sweets.

The obese individual is basically an unhappy person, although he may present an outward appearance of happiness. He feels frustrated, discouraged and sorry for himself. Food, particularly sweets, is the one thing in life he knows will invariably afford him pleasure. He seeks gratification in food during his moments of unhappiness and self-pity. He indulges himself in this pleasurable pursuit of eating, which signifies a regression to oral pleasures, whenever he feels that he has been denied the usual pleasures of life. Often, however, his complaints are unrealistic and his sense

of values immature, as exemplified, somewhat exaggeratedly, in the cartoon cited.

A young and fairly attractive girl felt miserable because her friends had frequent dates and she did not. Her only source of pleasure was in eating, particularly sweets. She said: "If life is not good to me, I'll be good to myself. I won't deprive myself of food—the one thing that can always give me enjoyment." Furthermore, when she ate she felt self-sufficient, not requiring anyone at that time to gratify her emotional needs. However, when a young man began showing an interest in her, her overeating stopped almost immediately.

Many patients report relapses in their dietary regimens whenever they have become discouraged with their efforts to lose weight. It is then that they feel sorry for themselves, bemoan their fates, and indulge in sweets. One patient who had been attending group therapy sessions for several months was told by a neighbor that she showed no appreciable weight loss. Her initial reaction was that of discouragement and self-pity. She immediately began to eat chocolate candy from which she had for some time abstained. Another patient read a magazine article in which some doctors claimed that dieting for the obese person is a lifetime proposition. She felt very sorry for herself because she was doomed to a life of continuous dieting and immediately proceeded to eat her favorite candy. A very obese patient had lost 30 pounds, which hardly made a dent in her over-all frame. She became discouraged because her friends had not noticed the change in her. Her reaction was: "Why should I go to all the trouble of dieting when no one observes that I have lost weight? It's not worth the effort, so I guess I'll start eating and enjoy myself again."

Food may also act as a reward. For example, the obese person may treat himself to an extra special meal or a sweet delicacy as a reward for what he considers to be a personal noteworthy achievement. One patient went to the restaurant and ordered a double serving of spaghetti, her favorite dish. She felt that she deserved this treat because she had completed her housecleaning, which was always an odious task for her.

Hostility

The role of hostility in overeating has not been emphasized in the literature. There is sufficient evidence, however, that hostility

is a very frequent—and probably the most important—cause for overeating. Perhaps the reason that hostility is overlooked is that it is so strongly repressed in the obese. The fat person is usually considered to be congenial and jolly; however, this demeanor is frequently a mask covering his deeply-rooted and intense hostile feelings. He represses his hostility because of his great fear of retaliation and disapproval, thus giving the appearance of passivity and submissiveness. These character traits often interfere with his sincere intentions of losing weight. Many patients report that they go off their diets whenever they are invited out to eat, simply because they fear they would offend their hosts if they refused to eat all the food placed before them. While on a reducing diet, a woman consumed a box of chocolates given to her by her mother. She thought that it would be very insulting to her mother if she declined to eat them.

The inability of the obese individual to assert himself or express hostility is a result of conditioning in early childhood. Anamnesis usually reveals a home environment where he was deprived of genuine love and sometimes even frankly rejected. In such cases, at least one of the parents was a cruel and strict disciplinarian. Any expression of hostility or rebellion was not tolerated. The child would be criticized unduly and given little, if any, emotional support. He was made to feel insignificant and inferior. (Many obese women express feelings of inferiority to an older sister or mother, who is considered prettier, slimmer and more talented. They also have a contemptuous, low regard for themselves.) The child, reared in this environment, has to repress his hostility because he fears that any expression of hostility would result in deprivation of love, in punishment, and in exclusion from the family.

Since the obese person is orally constituted, he resorts to oral mechanisms to solve his conflicts and express his aggressivity. Thus, hostility, although repressed, may be marifested in overeating; or, conversely, overeating may be an expression of some form of hostility. For example, overeating may indicate *defiance.*

A 32-year-old woman weighing 154 pounds, came to group therapy sessions because her husband wanted her to lose weight. He was a compulsive individual who arbitrarily decided that she should weigh no more than 132 pounds. Being dominated by, and somewhat fearful of, him, she was unable to express her anger at him verbally for this and other unreasonable demands. Overeating, however, was one method she was able to use success-

fully to express anger. She would sit before him at the table and flauntingly overeat, much to his consternation.

Many obese patients resent any active interference with their eating habits and will defy any imposition made on them. Eating, to them, represents independence; any interference with their eating habits is a threat to their independence, which they guard so avidly. Schick[13] describes a case of a young girl who took to abnormal eating in order to prove her independence of her family. Food was "at her command," and she could dispose of it "at her will."

During a group therapy session, a single, 22-year-old obese girl stated that she felt she was ready and able to go on a reducing diet. The therapist made a few encouraging remarks. On the way home, however, the girl bought pastries and other sweets which she proceeded to eat. She disclosed at the next session that she had been very angry at the therapist. She felt he was making demands on her to lose weight, and she was defying him by overeating.

As mentioned before, overeating may result from *repressed hostility*. Because of his insecurity and sensitivity, the obese person is easily hurt by frustrations, trivial criticisms and slight rejections. He reacts to this hurt with hostility, which he has to repress because of his fear of retaliation. The repressed hostility produces anxiety, and overeating is an attempt to allay this anxiety.

Rascovsky, et al.,[14] in discussing this problem, state: "The limitation imposed on the development of the more mature forms of sadistic expression keeps the obese always full of anxiety and with an ever-increasing voracity for food, because the oral capacity for canalization is always insufficient to satisfy their increased instinctive demands. . . . In all events, the oral mechanisms constitute for the obese the best psychic solution for the conflict which creates in them the intense aggressive accumulation. That is why it is common to find that the enforcement of a restrictive diet accentuates their melancholic or obsessive situation according to the organization of the ego in its different levels."

Several obese patients in the present study gave histories of migraine. This is interesting to note because these patients, like most obese patients, seemingly did not have the personality features characteristic of the migraine patient—such as perfectionism, ambitiousness, meticulousness, inflexibility, orderliness and obsessive compulsiveness.[15, 16] However, closer contact with these patients often revealed that many of these characteristics were present be-

neath their façade of passivity and complacency. The attacks were in most cases typical migraine in their symptomatology and were similar in dynamics—namely, repressed hostility. Relief was obtained in most attacks with Cafergot.

If the obese patient can, through therapy, become aware of his anger and express it, then the overeating due to repressed hostility will usually cease.

A young married woman started overeating one Christmas day and continued in this activity for several weeks. She revealed that she had been very angry at her husband because he had presented her with an umbrella instead of the nightgown that she had wanted. This revelation was followed by an emotional outburst of resentment against her husband which had been accumulating over many months. As a result of this ventilation in therapy, she was able to discuss some of her grievances with her husband. Immediately thereafter her overeating, at least temporarily, ceased.

During therapy, as hostile feelings begin to press into consciousness, there is usually an increase of overeating. At the same time, the patients concerned complain of irritability. As hostility is brought out and worked over, the overeating will diminish. Overeating can thus serve as a reflector for the therapist of what may be going on in the patient's unconscious.

Overeating may be an attempt *to deny hostility.* Like so many other neurotics, obese persons have an excessive need for approval and will avoid any thought or action that might antagonize another. They not only repress their hostility and become submissive, but will belittle themselves in an attempt to prove their harmlessness and deny the existence of any hostility. (Of course, the extreme nature of their actions belies the true state of affairs.)

They accomplish this belittlement by overeating and becoming fat. This is especially true of the woman who believes that making herself attractive is a hostile act since it implies a desire to compete with other women. The relation in her mind between attractiveness and competition probably has its origin in the early Oedipal rivalry when the little girl desires to displace her mother; or, in some cases, to displace the other siblings and get all the parents' attention. Bychowski[8] describes a case in which part of the motivation for overeating was that "in making herself unattractive she was giving up the oedipal rivalry with her mother and was clearing the place for her."

B. L., a 27-year-old, attractive young woman, had an overeating problem. Although endowed with natural intelligence and outstanding sales ability, she always fell just a trifle short of being the top producer in her field. She would methodically slow down in her efforts just as success was almost within her grasp. Psychoanalysis revealed that, in her unconscious, success was equivalent to defeating a rival and thus was a hostile act.

She was the middle child in a family of seven children. Her father was an unstable individual, who behaved inconsistently toward his children. He would either shower them with love, which at times was suspiciously seductive, or behave like a tyrant, physically abusing them. The patient was her father's favorite, and he was openly partial to her. Although she secretly longed for her father's love, she made no attempt to seek it because she dreaded the jealous wrath of her siblings and mother.

This fear of being the favorite (and, therefore, outstanding) in her home was carried over into her other relationships and activities. Although she had charm and looked attractive, she made an effort, particularly when in the company of women, to appear unattractive and ordinary. If, by chance, she received an award or some other recognition from the company which employed her, a mild depression and overeating would ensue. Her overeating was an unconscious attempt to placate the other women in the organization and deny her competitive strivings, as if she were trying to say: "Don't be angry at me because I won—just look at me and see how ineffectual, miserable, fat and ugly I am."

The overeating of the foregoing categories is usually moderate, more or less controlled, and consists mainly of high carbohydrate foods. Often, however, there are cases where overeating becomes uncontrolled, and the individual eats ravenously. He gorges himself with all kinds of foods, especially bulky and spicy foods. This eating "binge" can continue for hours or until it is impossible to ingest any more food. This type of overeating is invariably associated with hostility. In this case, however, the hostile feelings are so intense that the eater wants to destroy the person he hates; thus, his voracious eating is a symbolic representation of this destruction—by devouring—of the hated object. This is cannibalistic *oral incorporation.* This dynamic mechanism has, interestingly, become part of our language: We sometimes refer to this type of hatred as a "consuming hatred."

The unconscious awareness of the hostile implications of this act accounts for the intense guilt feelings which accompany or follow this type of eating—more so than in the case of any other type. Depression, remorse and self-recrimination are common reactions to this type of eating. Nausea and vomiting may occur

during or immediately after the eating bout. This may be a reaction to guilt or may represent an attempt, after the eater's fury has been spent, to undo his hostile act and rid himself of the incorporated object. In some patients the guilt feelings are so intense following this type of eating, that they are prone to break appointments rather than face the therapist who may represent a superego surrogate.

Treatment

Losing weight is not easy for most patients. It is a long and difficult process, fraught with many frustrations, disappointments, failures and some pain. The restrictions placed upon their former eating habits deprive the patients of their primary means of allaying their anxiety, deriving gratification, and handling hostility. It behooves the physician to be understanding of this problem. Any impatience, misunderstanding and undue criticism of the patient's inability or slowness in losing weight will seriously interfere with the therapeutic relationship and, hence, with progress. Of course there are some physicians who by their critical, punitive and authoritarian attitudes actually frighten patients into losing weight. Needless to say, any success obtained by this technique is at best only temporary, for the weight returns as soon as the patient is freed from the physician.

Psychotherapy is the primary and most important treatment tool in overeating and obesity. Recently, the group therapy approach to this problem has come into prominence, and in several respects is superior to individual psychotherapy. The working together, the sharing of a mutual problem and the support that the patient receives from the group are some of the beneficial contributions of group therapy. As the patient progresses in therapy, it is sometimes useful to prescribe reducing diets and drugs (such as those causing anorexia and the bulk-forming) to help hasten the weight loss. These, however, are merely adjuncts and, in most cases, valueless without concomitant psychotherapy, for the impulsion to eat is much stronger than the opposing force of a restrictive diet and drugs.[17, 18] Furthermore, without psychotherapy, these adjunctive agents can be more harmful than beneficial. For example, a patient's inability to stay on a diet and his disappointment in not being able to, may result in increased overeating. Further, the reliance upon drugs may lull the patient into a false sense

of security; he continues to overeat, depending on the drug to perform some miraculous change in his weight.

One of the early tasks in therapy is to find the emotional cause of the patient's overeating. A detailed knowledge of his overeating is very helpful. What types of foods does he eat? What is the pattern of his eating—between meals, all day long, at certain times of the day, etc.? What is the environmental situation, or what are his feelings before overeating? How intense is his guilt after overeating? Such information will give an understanding of the implications of the overeating—whether it is an attempt to allay anxiety, a means of obtaining gratification, or an expression of hostility. This knowledge then will provide important clues to the underlying emotional problems.

If the problem is that of anxiety, it is necessary to find the basic cause of the anxiety. One must help the patient gain insight into his problems and then give him sufficient ego-strength to handle them in a mature way. If overeating is a problem of self-gratification, one must discover the reasons for his discontent and self-pity. Usually, discontent and self-pity are unrealistic and neurotically conditioned, thus amenable to psychotherapy. If they are due to more or less realistic factors, one must help him to discover for himself more constructive and more wholesome ways of obtaining pleasure than regression to the pleasures of orality. Finally, overeating may be an expression of hostility. Here psychotherapy can help the patient become less sensitive to life's frustrations so that less hostility is generated, and also help him to handle in a mature way any hostility that does develop. In brief, the aim of psychotherapy in overeating is to help the individual handle his problems in an emotionally mature way rather than by immature, oral mechanisms.

Summary

1. Overeating implies the existence of an emotional problem.

2. Overeating may be used to: (a) allay anxiety; (b) obtain gratification; (c) express hostility.

3. Because the overeater is orally fixated, he regresses to oral mechanisms whenever he has anxiety. Food, particularly high carbohydrate food, has an unconscious significance for him and temporarily helps to allay his anxiety.

4. The individual who is discontented and inclined to self-pity may resort to food as a prime source of pleasure and gratification.

5. Eating as an expression of hostility may denote: (a) defiance; (b) repressed hostility; (c) denial of hostility; (d) oral incorporation.

6. An understanding of the implications of overeating will afford the therapist a clue to the patient's underlying emotional problems.

7. Since overeating and, hence, obesity are psychological problems, the most effective treatment is psychotherapy.

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SUICIDE: AN EPIDEMIOLOGIC ANALYSIS*

BY JAMES M. A. WEISS, M. D., M. P. H.

EDWARD [The Patient]: And since then, I have realized
That mine is a very unusual case.

REILLY [The Psychiatrist]: All cases are unique, and very
similar to others.

—*T. S. Eliot.*

The suicide of a patient, because of its finality, is perhaps the most devastating experience in the practice of psychiatry. And suicide, if considered as a form of mental disorder, is the prime cause of death among psychiatric patients, except in the oldest age groups. Much has been learned about suicide from clinical studies of individual patients, but psychiatrists have been unable to explain or predict the *patterns* of suicide as they occur in groups of people under ordinary or special environmental conditions. Knowledge of these patterns—obviously of great importance in understanding and preventing suicide—can be gained only through the methods of epidemiology.

The nature of suicide is very complex, but it seems evident that there are three chief etiological factors: the group attitudes in each particular society; the adverse extraneous situations which the individual must meet; and the interaction of these with the character and personality of the individual.

Obviously, different individuals meet adversity differently. One whose personality is poorly integrated may respond to a stress situation by taking his own life. Yet anthropologists[1, 2] have demonstrated that suicide is completely unknown among certain primitive tribes, that suicide rates are extremely low in certain Catholic countries, and, alternatively, that suicide is not only acceptable but obligatory as a consequence of specified activities or happenings in certain other cultures. However, as cultural patterns affect large numbers of people who do not always act similarly, and as every person must meet difficult and dangerous situations in

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an environment which can never be "sterilized" psychologically, it appears likely that personality disintegration is the most important single variable in the etiology of suicide. The psychiatric concept applies that external tensions are reacted to in proportion to the amount of internal tension already existing.

Most psychiatrists and analysts have identified suicide with aggressive tendencies. Schilder[3] believed that "suicide is obviously merely a symptom and not a clinical entity," and that suicide can serve as a form of self-aggression, or as self-punishment for aggressive behavior previously directed toward another (loved) person, or as a form of punishment for a person who may have earlier denied love to the subject, or as a form of peace (or reunion with a love object), or certainly as an escape from insupportable difficulties. Alexander[4] considered suicide an extreme example of the disintegration of isolated aggressive impulses which are normally subordinated; and Freud[5, 6] emphasized that suicide is often the result of aggression directed toward an introjected love object; that is, a love object with whom the subject had previously identified himself.

Gordon[7] has pointed out that there is a "biologic gradient" in any illness in a living organism, that each disease varies clinically and can end in uneventful recovery, complication, or death. In suicide, we know only about those cases that terminate fatally; by definition, suicide is a violent self-inflicted destructive action resulting in death. Thus suicide may be considered the fatal end in a type of mental disorder which, prior to its termination in death, is in itself marginal and poorly described. Lindeman[7] suggested that this mental disorder which *may* end in "suicide" be termed *"hypereridism"* (from *Eris*, the Greek goddess of wrath and anger). "Hypereridism" may be defined as "a state of readiness for violent behavior" or "a morbid state of [emotional] tension." It is a form of aggression that may or may not end in suicide.

In any case, the outcome of the disorder is clearly affected by the relationship of the individual to his environment, and suicide can be considered as one outcome (the fatal end) of an ecologic process representing the reaction between a host and his environment.

The validity and importance of epidemiologic studies as an adjunct to clinical analyses, in mental illness in general and in suicide in particular, were thoroughly discussed and justified by participants in the Milbank Memorial Round Table Conference on the

Epidemiology of Mental Disorder.[7] At that conference, Faris cited the case of a scientist who made a newspaper statement to the effect that the marked decrease in United States suicide rates in the decade from 1937 to 1947 was undoubtedly due to the great popularity, during that period, of electric shock treatment of the mentally ill. Had this scientist been informed epidemiologically, he would have known that suicide rates almost invariably decrease in periods (as in the decade cited) of war and/or prosperity.[7, p. 123]

The methods of modern epidemiology are being used to study many illnesses, in order to determine their nature, etiology, and means of spread, so that these disorders can eventually be controlled or prevented. Such methods can be applied to illnesses which do not occur in classical epidemic form, although it is in the groups of these latter that the methods have had their most conspicuous success. Although suicides *have* occurred in epidemic form (United States in 1930, Copenhagen during World War II), they generally are not manifested as such violent reactions under such singular circumstances. A "law of series" in suicides, claiming a high probability that after one suicide in a given location more will follow, has been mentioned in many earlier works. However, modern data indicate that such "series" usually consist of only two to four cases and, although widely publicized, occur but rarely. Systematic study of suicides as they occur in any group of people in any delineated time and place provides basic information. Such epidemiologic studies are facilitated by the fact that traumatic and legal aspects of suicide render raw data (relating only to "mortality rates," of course) easily available.

Planning such a study immediately raises certain problems. Probably analyses of the epidemiology of homicide can be validly omitted, for homicide clearly involves two persons and is an aggressive act directed externally rather than toward the self. The problem of attempted suicide is perhaps more complex. There are two large difficulties involved in analysis of attempted suicides: practically, the lack of complete statistical data (for most attempted suicides are not reported as such); theoretically, the difference in psychological mechanisms (for many attempted suicides are intended not to end life but only to serve as gestures). The true suicide must expect to kill, be killed, and die, writes Menninger.[8, 9] In a study of all reported suicides and suicide attempts in

Detroit during 1942 and 1943,[10] it was found that the success of the attempt varied markedly with the "motive" ascribed, and that where there was little chance that an individual could gain by using suicide solely as a gesture, the attempt was more likely to be successful.

Certain facts are known about unsuccessful suicide attempts.[11] They are much more common among females than males, and this is especially true in the population group under 30 years of age. The percentage of successful suicide attempts becomes greater with greater age: Attempted suicides among the young are the least successful. The most efficient suicide methods (drowning, shooting, hanging, jumping from high places) are generally more common among men, whereas females are more likely to use poison, the least efficient method.

The problem of unconscious motivation is even more complex when related to accidents, which may be purposive in nature. Here the practical difficulties in collection and analysis of data are so involved that adequate statistical evaluation appears to be impossible. And, any collection of suicide records will have an understated total, for many suicides are never so reported. (There is a slight compensation in the fact that some clever homicides are probably reported as suicides.) However, Dublin, who has studied the problem most thoroughly,[12, 13, 14] believes that analyses in limited categories, made with suicide data collected in the United States since 1900, will be both valid and reliable.

Patterns of Suicide*

Patterns of suicide show marked variation from culture to culture, country to country. Although Zilboorg[22] reported that suicide was in general much more frequent among primitive races than among civilized people (contrary to the common impression), there are certain primitive, as well as certain civilized, cultures in which suicide is almost or completely unknown. In the period 1930 to 1934, when good statistics were available from almost all civilized countries, the Irish Free State had the minimum yearly suicide

*The universal fascination of the study of suicide is reflected in the great bulk of literature concerning this subject. Classic descriptions of suicide have been reviewed elsewhere (Rost, Ref. 15; Dahlgren, Ref. 16). Among the most important investigators were Elvert, Ref. 16; Osiander, Ref. 16; Falret, Ref. 16; Esquirol, Ref. 17; Casper, Ref. 16; Etoc-Demazy, Ref. 16; Boismont, Ref. 16; Morselli, Ref. 18; Durkheim, Ref. 19; Cavan, Ref. 20; Gruhle, Ref. 21; and Dublin and his co-workers, Refs. 12, 13, 14.

rate of only 3.4 per 100,000 population. At the other end, Austria had a yearly rate of 40 suicides per 100,000 population. The Germanic countries and Japan had very high rates; Denmark, Finland, and France had moderately high rates; the United States was in the middle (16 suicides per 100,000 population per year); and the rates were progressively lower in England, Wales, New Zealand, Canada, Scotland, Norway, Australia, Northern Ireland, Italy, the Netherlands, and Spain.[14]

Although certain basic patterns are common in all civilized countries (e. g., a predominance of suicides among older males), there are great differences in gross rates, trends, and special patterns, probably because of the great varieties of traditions and customs, religious convictions, social viewpoints, temperaments, climates and other conditions.[13, 14, 23, 24, 25, 26] As this study is concerned primarily with local and national patterns in America, the statistics to be reviewed in the following are related only to United States patterns of suicide (except in a few instances, where specifically stated).*

Extent and Trends

It has been estimated that in the past half-century there has been an average of 20,000 suicides per year in the United States, and that suicide has been the country's twelfth cause of death. If present trends continue, 18 white males out of every 1,000 born, and five white females out of every 1,000 born, will eventually commit suicide. Though responsible for only about 1 per cent of the total deaths from all causes in the MLI group, suicide has consistently been the cause of 10 to 12 per cent of the deaths due to external causes—a poor second to accidental violence, but more important than homicide or (through the years) wounds of war. The

*Unless otherwise noted, the statistical data following have been taken from the publications of Dublin and his co-workers (Refs. 12, 13, 14) and from the Statistical Bulletins of the Metropolitan Life Insurance Company (Refs. 10, 11, and 27 through 41). One objection is that most of Dublin's data are related to policy-holders in the Metropolitan Life Insurance Company. This very large scattered group, of both sexes, all ages, and many races, (hereinafter referred to as the "MLI Group") is of course differentiated from the general public because its members have the financial ability to own life insurance policies. However, Dublin has published numerous analyses comparing the suicide patterns of the MLI group and those in the United States Death Registration Area, showing the two patterns to be very similar. It appears that the MLI group is a sufficiently large and representative sample so that its patterns are usually those of the nation as a whole.

average annual suicide rate of the MLI group from 1911 through 1945 was approximately 10 per 100,000 population.

These figures do not give the total picture, for at specified times among specified groups, suicide is considerably more important. Suicide is more common among older age groups, and suicide rates increase in older populations. In the same way, changes in sex or racial ratios in any population affect suicide rates. Thus rates specific or standardized for age, sex and race must be used to reveal the true picture.

Such rates have been computed for the MLI group.* In 1911 the standardized rate for this total group was 16.5. In 1915 this rate began to fall, dropped markedly throughout World War I to a record low of about 7 in 1920, then began a slow climb to about 9 in 1925. From 1925 to 1932, the ascent was more rapid, and a peak of 12.8 was reached in 1932. Then a gradual decline commenced, down to 6.3 in 1945 (the lowest rate of the past 40 years). Similar low rates were present throughout World War II, but the downward trend for United States suicides was abruptly reversed after V-E Day, and from 1946 to 1949 the rates ran from 7.2 to 7.5. In 1950 the rate dropped again to 6.6.

These general trends were also seen in population groups broken down by sex and race, but rates were considerably higher and trends more marked for white males alone than for the total group, and colored male suicide rates were lower, with less pronounced trends. White female rates were still lower; and colored female rates were the lowest, with the trend pattern among colored females barely discernible (i. e., the colored female trend was almost a straight line, slowly decreasing over the past 40 years).

Influence of War and Economic Conditions

Gross inspection of United States suicide trends reveals two striking correlations: suicide rates decrease during war, and increase during depression. The wartime drop appears to be a universal phenomenon which has been reported as occurring in all wartime countries, and has been observed even in some neutral nations during wartime. This phenomenon is always more marked among men than women, and in this country more marked among white than colored persons. Usually there is a lag period of low

*These rates, and all other rates unless specified, represent deaths from suicide per 100,000 population per year.

suicide rates after a war, which was true in the United States after World War I but not after World War II. Dublin[12] believes that suicide rates decrease during war because wartime is usually a period of high employment, and also a period when personal problems are minimized. The sudden reversal of suicide rates after World War II was attributed by Dublin[37] to the sharp cutback of industrial activity and consequent reduction in employment immediately following V-E Day (the cutback after World War I had been less marked and more gradual), and to the large numbers of servicemen facing sudden adjustment to civilian life.

The general inverse parallelism of suicide trends with economic conditions is also obvious. Dublin[14] computed suicides rates and general business condition indices from 1911 to 1935 by refined statistical techniques. Comparison of the indices revealed a general tendency for below-normal suicide rates to occur in times of above-normal business conditions, and this correlation was most marked among urban white males.*

Influence of Season and Weather

The relation of suicide rates to weather and seasonal changes is subject to considerable dispute. It is generally believed that rates reach a peak in spring and show a secondary rise in autumn. Dublin[14] noted a consistent tendency in United States data for suicide rates to reach a peak in May, decrease gradually to December, and then increase gradually. Blumer[42] found the rates of 1,552 suicides in Zurich (1923-1942) to show the highest frequency in spring and summer and the lowest in autumn, and noted that in 70 per cent of the suicides the weather on the day of suicide was of a definitely different character from that on days of low suicide rates. But Dublin[13] attempted to correlate suicide data of New York City (1910 to 1923) with temperature, humidity, wind velocity, and many other weather variables, and found no significant correlation. Ipsen[7] believes that seasonal variations, if any, are small and due to extraneous factors.

Age and Sex Distribution

It is an outstanding fact that suicide in white America is concentrated in the older ages of life: the rates increase consistently with

*Gruhle (Ref. 24) noted that in Germany and Scandinavia the greatest increases in suicide rates during major economic crises were among the richer groups, whereas the lowest increases were among the urban poor (whose poverty was apparently not much affected by the changing economic conditions).

each advancing age period. More than one-half of all suicides in the United States occur in the age group of 45 years and older—although this group comprises only one-fifth of the total population. The male:female ratio of suicide rates, which for the collected data of the past 40 years averaged about 3.5:1, increases sharply with every advance in age. Up to the age of 19 the rates for white males and females are very similar, but the white male rate advances sharply in each succeeding age group, whereas the white female rate advances only very gradually with age—so that in the age group 65 to 74 years the male:female ratio is about 6:1.

These general age and sex patterns have remained constant in white America during the past 40 years, although the general age-standardized trend has been declining, as reported in the foregoing. In the period of rising rates from 1920 to 1932, the greatest increase in white male rates was in the "45 years and older" age group. In the decline from 1932 to 1950, the greatest reduction was also among males over 45 years of age. Female rates were lower throughout, however; and, with the declining rates since the depression, the younger white female group showed a much greater decline than the older.

Because of the often spectacular and tragic nature of the suicides, those of children and adolescents are sometimes thought to be rather frequent. Actually, suicide before the age of 20 is very rare, and even in this youngest age group the rates have shown a consistent downward trend.

Race and Color Incidence

Although homicides are generally (and correctly) held to be much more common among Negroes than among whites, the opposite is true of suicides. In the early age groups rates are rather similar, but after the age of 25 the white:non-white ratio of suicide rates increases sharply with every succeeding age period. The over-all age-standardized white:non-white ratio has been about 2.5:1 to 3:1 in the United States in the past 40 years. This striking difference in patterns is noted: Negro male rates rise (at about the same degree as the white) to the age of 25, and then level off with perhaps only a very slight increase in the succeeding age groups. Negro female rates are even more singular in that suicide rates in this group reach a peak at age 25, and then *decline* in every succeeding age period.

Although Negro rates are markedly lower than white rates, the rates of races neither white nor Negro (e. g., Indian, Chinese, Japanese, Filipino, Hindu) are consistently higher. Japanese and Chinese suicide rates in the United States are especially high.[7, 13] Indian rates appear to vary from tribe to tribe.[13, 43]

Methods

Early in the nineteenth century, one Matthew Lovat, an Italian shoemaker in Venice, attempted to commit suicide by nailing himself to a cross. Other fantastic suicide methods in history have included swallowing red-hot coals, self-suspension from a bell clapper in a village church, and beheading with a self-made guillotine.[13] Most people, however, choose one of a very few common suicide methods. In the United States in the past 40 years, over three-fourths of the total suicides were committed by shooting, poisoning, asphyxiation by gas, or hanging. The remaining one-fourth chose drowning, cutting or stabbing, jumping from high places, crushing, or a few miscellaneous methods.

With the top four places there has been considerable shift. Shooting, in first place, is more common now than at any other time since 1921, with a male:female ratio of 2:1. Hanging is increasing markedly in both sexes. Poisoning is decreasing in both sexes, but is still two times more popular among females than males. Females are making more extensive use of the more violent and disfiguring means of suicide (hanging, shooting, and jumping); the more passive means of suicide (asphyxiation by gas and poisoning) have become less common for males and females alike.

Almost one-third of the white male suicides choose shooting, and one-fourth choose hanging (one-third of those aged 45 or older). Asphyxiation by gas is in third place, being used mostly by those in the older age groups; whereas, in the younger age groups, poison is preferred as the third most popular method. One out of four white females who commit suicide chooses hanging; poisoning, a strong leader in this group for many years, is now chosen by only one-fifth; asphyxiation by gas is in third place (except in the older age group where it is as popular as hanging and where poisons assume third place); shooting is the fourth choice.

Almost one-half of colored male suicides shoot themselves, one-sixth use poisons, and smaller numbers choose hanging. Asphyxiation and cutting or stabbing share fourth place. Colored females,

on the other hand, prefer poison (used by one-half of the colored female suicides) or shooting (used by one-sixth); smaller numbers choose drowning, asphyxiation by gas, or jumping from high places.

Ipsen[7] believes the choice of suicide method is based mainly on availability of the means, and cites the record in Denmark, where firearms are difficult to obtain and where only 2 per cent of male suicides result from shooting. Dublin[13, 14] recognizes the importance of availability, but points out the multitude of means available to any determined seeker of suicide. A second factor in choice is probably suggestion. But Dublin believes that individual psychological factors are most important: "In general, it seems rather clear that the mental economy of the suicide is such that he will go to great lengths to kill himself in some particular manner that for some personal reason offers him the greatest satisfaction."[14, p. 415] A case in point is that of the would-be suicide who some years ago jumped from the Brooklyn Bridge.[13] Conscious after hitting the water, he refused to grab a rope lowered to him by a nearby policeman—refused, that is, until the policeman threatened to shoot him!

Heredity and Nativity

There appear to be no studies in the literature in which any tendency for suicide to run in families is well-defined. Kallmann and Anastasio[44, 45] studied suicide in twins, and found no evidence to suggest any definite hereditary factor.

Nativity, on the other hand, exerts a well-known influence on suicide rates. The foreign born in this country have significantly higher rates than the native born, and the suicide rates of foreign born in the United States are generally higher than those in their country of origin. Also, the suicide rates of United States foreign born are generally similar in rank to the rates of their respective homelands.

Place of Residence

The total suicide rates in the southern states in this country are generally lower than the national rates, but this is in part due to the large numbers of colored people (with low rates) in the south. Porterfield and Talbert[46] studied the relationship of "social well-being" to suicide in the 48 states and in 19 large cities, and found

no definite correlation but a variable tendency for low suicide rates to occur in areas of low social well-being (e. g., Mississippi had the lowest "social well-being index" and the lowest suicide rates).*

Religious Affiliation

Suicide mortality is generally lower in countries where a large proportion of the population is Roman Catholic, and the Catholic rates in most countries are lower than the Protestant. The suicide rates in the Irish Free State (predominantly Catholic) are significantly lower than those of Northern Ireland (predominantly Protestant), although both countries have very low suicide rates. Rates among Jewish people appear to vary markedly from time to time and place to place. In the United States, certificates of death do not list religious affiliation, so that no large scale studies have been made.

Difficulties in estimating the importance of religious affiliation in any country are that no measure of devoutness is possible, and that *rates* are seldom used. Raines and Thompson[47] cited the work of Franks, who studied case records of 626 successful suicides and 342 proved attempted suicides (Toronto, Ontario, 1928-1935) and found yearly rates of 4.5 suicides per 100,000 Protestants, 5.6 suicides per 100,000 Hebrews, and 11.0 suicides per 100,000 Roman Catholics. Raines cited his own study of suicides among United States Navy enlisted men, and that of Wallinga[48] in St. Paul, Minn., to indicate that suicides among United States Catholics are proportionate to, or higher than, their numbers in the general population. He attributed the lower rates in Catholic countries to the fact that religious attitudes become a part of the culturalization of the country.

Marital Status

The age-adjusted rates among the married, of either sex, are much lower than the rates for the single, widowed, or divorced—and this is especially true for males. The divorced of both sexes have the highest rates, and the rates for the widowed (said to be very high) are, when age-adjusted, lower than those of the divorced or single.

*The social well-being index was based on measures of economic welfare, education and culture, living conditions, voting franchise, medical facilities, and general goodness of health.

Relation to Illness and Disability

Stearns[49, 50] found 15 per cent of 160 suicides in Massachusetts in 1922 to have some concomitant physical disease (usually cancer, or cardiac or pulmonary disease), and 33 per cent were listed as suffering from "mental illness." Kramer,[7] in a study of 3,631 suicides, found "mental disorder" listed as a contributory cause of death in 39 per cent; of 2,211 suicides in the MLI group in 1923-1924, "insanity" was directly mentioned as a contributory cause of death in 19 per cent. Jamieson[51] analyzed case records of 100 mental hospital patients who committed suicide in the hospital or after discharge, and noted that 46 had been diagnosed as manic-depressive psychotics, 19 as involutional melancholiacs, and others as psychotics of various other types, or as severe neurotics. Jamieson, Raines,[47] and Bond[52] all point out that suicide is not uncommon among schizophrenics, especially paranoid types. Bond also emphasizes the prevalence of suicide in three main types of mental illness: manic-depressive psychosis (especially on an "upward swing"), involutional melancholia (which carries with it an "enormous sense of guilt"), and in delirium (where unplanned suicide may result from the patient's confused state).

Unfortunately, "depression" and "depressive psychosis" as mentioned on suicide death certificates are probably most often post-mortem diagnoses. Zilboorg[53] believes that only a small per cent of suicides are committed by depressive psychotics, and that most suicides are committed by persons considered "normal" before the act. Undoubtedly many persons who commit suicide exhibit some form of depression ante mortem, and certainly suicidal ideas are characteristic of the individual with a true depressive psychosis, but Raines,[47] examining 164 naval enlisted men who attempted suicide in 1947-1949, found at the most 10 per cent who could be classified as having true depressive psychoses.

Socio-Economic Status and Occupation

Official death data in the United States provide no definite index of socio-economic status. The only fairly adequate study of the relation of suicide mortality to socio-economic status is the *Report of the Registrar-General of England* in 1927 (cited by Dublin[13]). White male suicides throughout England and Wales were analyzed by occupation (using age-standardized data), and it was found that

laborers (skilled and unskilled) had rates below the average rate for all civilian males, and professional and white-collar groups had above-average rates. The highest rate was in the class designated "never occupied," in which the very rich, dependents, unemployed, tramps, inmates of institutions, etc., were all lumped together indiscriminately. When age-specific data were examined, it was found that after the age of 65, the "never-occupied" group had a very low suicide rate, while the professional-and-white-collar group had *below*-average and the laboring group *above*-average rates.

Surprisingly, age-standardized data for the MLI group in the United States (1911-1931) showed industrial policy-holders (mostly in the "laboring classes") to have consistently higher suicide rates, in all age groups after the age of 20, than ordinary policy-holders (mostly white-collar groups, with some skilled laborers and a few professional and business people).

These contradictory studies are obviously not conclusive. It is difficult to estimate the relation of occupation *per se* to suicide, because of the many other factors involved. For example, physicians are generally believed to have very high suicide rates, but with age-adjusted data their rates are only slightly above those of the white male general population; and further breakdown reveals that the rates of medical specialists are probably lower than those of white males in the general population.[7, 28, 36] It has also been assumed that suicides are more common in groups engaged in intellectual work. But specific occupational breakdown in the English study just cited revealed little relation of suicide rates to either intellectual or manual labor.

Suicides in New Haven, 1936 to 1950: Approach to the Problem

The preceding discussion reveals that although certain basic patterns in the epidemiology of suicide are recognized, there are many phases of the problem that need further investigation. For this purpose, there is considerable advantage in the selection of data for initial exploration from restricted areas in time and place. For several important reasons it was decided to use death certificate data in the city of New Haven, Conn., as raw material for the present study. First, these data are available, and are sufficiently consistent and complete to provide necessary information for valid

and reliable analysis. Second, population characteristics of this city are available, so that rates can be computed and comparisons made. Third, previous ecological studies made in New Haven provide indices of socio-economic status, based on place of residence in the city, so that the relation of socio-economic status to suicide mortality (past investigation of which has been very limited and confusing) can be analyzed.

New Haven is the second largest city in Connecticut. About 20 per cent of New Haven's population of 160,000 are foreign born, and it is estimated that at least 40 per cent of the population are of Italian extraction. The total population remains very stable in amount and proportion; in 1920 there were 162,537 residents; in 1930, 162,655; in 1940, 160,605. The percentage of foreign born has been decreasing slowly (28 per cent in 1920, 20 per cent in 1940), and the percentage of older age groups has been increasing very slowly. The percentage of Negroes is about 3.88. The male: female ratio in the general population is consistently 1.00 to 1.04 or 1.05. There are very few non-white non-Negro residents: only 108 residents were listed in this category in 1940.

For some years various sociological investigators have studied New Haven to delineate the relationship between its geographical areas and the city's social structure. In 1937 Davie[54] published his analysis: a division of the city into ecological areas, each of which was relatively homogeneous for a large number of social characteristics. Continuing studies were made of the changes occurring in the city, and in 1947 the Neighborhood Planning Committee of the New Haven Council of Social Agencies prepared a *Neighborhood-District Plan* of the city of New Haven.[55] This plan, based on analysis of data collected in the 1940 decennial census, divided the city into geographical districts of homogeneous nature; and the socio-economic characteristics of each were described (on the basis of population and housing data).

The *Neighborhood-District Plan* was utilized in the present study, for it includes extremely valuable information which makes possible the identification of a neighborhood district for any address in the city, and further classifies the neighborhood districts into gross socio-economic groups. These gross socio-economic groups (hereinafter abbreviated to "GSE Groups"), delineated on the basis of the principal population characteristics of the neighborhood districts, are described as follows:

GSE Group A is characterized in general by high average monthly rent, low population density, good housing, low percentage of children, high percentage of older age groups, low foreign-born white population, and low percentage of Negroes.

GSE Group B is characterized in general by moderate average monthly rent, low population density, good housing, fairly even distribution of population by age groups, low foreign-born white population, and low percentage of Negroes.

GSE Group C is characterized in general by low average monthly rent, moderate population density [variable quality of housing], high percentage of children, low percentage of older age groups, low foreign-born population, and, except in Neighborhood District 8 (in which about two-thirds of all Negroes in New Haven live), low percentages of Negroes.

GSE Group D is characterized in general by low average monthly rent, high population density, substandard or slum areas, high percentage of children, low percentage of older age groups, high foreign-born white population, and low percentage of Negroes.

For the present study, all death certificates recorded in New Haven from 1936 through 1950 were examined, and data were collected from all of those in which suicide was certified as the cause of death. The total number of such cases (certified suicides) was 278. The collected data were then coded on IBM cards. Most of the data were subject to clear-cut classification and grouping, but in certain categories arbitrary classification was necessary.* The data were then sorted, tabulated, and analyzed. In general the patterns of analysis set by Dublin and others were followed, so that similar bases for comparison would be available. It was necessary to limit, in certain ways, the cases to be analyzed. Certain groups of suicide cases were listed as "supplementary groups," and ex-

**Occupational class* breakdowns were based upon those developed by Chapin, Warner, Hollingshead and others (Refs. 56, 57, 58). *Methods of suicide* were classified according to the latest revision of the International List of Causes of Death. Date and place of *suicide occurrence*, rather than date and place of death, were coded. "Antecedent causes of death" and "other significant conditions [relating to death]" were grouped, when applicable, under the heading "*Contributing Illness,*" and subdivided grossly by type, severity, and duration. Addresses (usual residences) were classified by Neighborhood District for coding, and later grouped by GSE Groups.

cluded from the main body of cases (termed the "basic group").* The remaining "basic group" consisted of 218 persons, all of whom were white residents of New Haven who committed suicide in New Haven. Unless otherwise noted, all of the findings reported were based on analysis of this basic group only. It is important, however, that the general patterns which prevailed in the basic group were found to prevail also in the single or combined supplementary groups, and that analysis, following random addition to the basic group of single or combined supplementary groups, did not show significant changes in the demonstrated patterns of suicide in New Haven.

Patterns of Suicide in New Haven

Extent and Trends

During the past 40 years, New Haven suicide rates have been consistently equal to, or slightly higher than, mean suicide rates in the continental United States. This is also true for the 15-year period covered in the present study, for there was an average of 14 to 15 suicides per year (an average rate of 9.5) in the basic group of New Haven suicides, and for the same period the MLI mean rate was 8.1.** Suicides comprised from 1 to 2 per cent of all causes of death in New Haven each year during the 15-year period 1936-1950.

Although the curve of suicide mortality rates in New Haven is rather irregular when plotted year by year, the over-all trend of suicide rates in New Haven is fairly similar to the national pattern. The New Haven basic group had a rate of 12.4 in 1936. The rate dropped slightly and leveled during the next three years, and then rose to a peak of 13.0 in 1940. The rate then dropped sharply throughout the years of World War II to a low of 5.2 in 1944 and

*These "supplementary groups" included: nine non-whites—(all Negroes)—the number was too small for statistical significance; 30 non-residents of New Haven who committed suicide in New Haven—data from these cases could not be related to New Haven population characteristics; five residents of New Haven whose usual addresses were not listed—neighborhood district data could not be determined; and 16 residents of New Haven who committed suicide away from New Haven—their "attested copies" of suicide certificates sent from nearby cities undoubtedly represented only a small sample of the total number of New Haven residents who committed suicide away from the city.

**Unless otherwise noted, all "rates" mentioned refer to the *mean number of suicides per* 100,000 *white population per year,* based on the population characteristics listed in the 1940 census and the *Neighborhood District Plan* (Ref. 55.)

7.6 in 1945; dropped again to the lowest rate in the 15 years, 4.6 in 1946, and then rose slowly to 10.4 in 1950. During these 15 years, an over-all decline took place in all groups, but by far the highest rates throughout were found in the white male group aged 45 years and older.

The correlation between suicide rates and business conditions noted in long-term analyses of the national pattern (i. e., that low suicide rates occur in times of prosperity) apparently also held true for New Haven whites in general and especially for older white males.

White male and female yearly rates, averaged by five-year periods for all ages, are listed in Table 1. It may be seen that the male:female ratio declined during the war years and increased in the postwar period. This agrees with the national pattern, that male rates always drop more than do female rates in war periods.

Table 1. Sex-Specific Yearly Suicide Rates, Averaged by Five-Year Periods, for New Haven, Conn., from 1936 through 1950.

	1936-1940	1941-1945	1946-1950
Males	16.9	12.4	12.2
Females	5.8	5.1	4.6
Male:Female Ratio	2.9:1	2.4:1	2.6:1

Age and Sex Distribution

Childhood and adolescent suicides were extremely limited in the New Haven basic group. There was no record of any suicide committed by a person under the age of 15, and the rates in the age period 15 to 19 years were very low.

The white male group demonstrated an advancing suicide rate in every succeeding age group, but the white female rate took a large jump in the 25-34 age group, and remained rather irregularly at this higher level. When the female rates were grouped by larger age periods (for only 61 of the 218 basic cases were females), rates of 0.3, 5.5, 9.8 and 8.1 were obtained for the age groups 0-19 years, 20-44, 45-64, and 65+ respectively. Male rates for the same four age periods were 0.3, 8.2, 29.4 and 55.8 respectively. Thus female rates showed a gross tendency to increase with age, but at a much slower rate than male rates. The over-all male:female ratio of suicide rates was 2.7:1. This ratio was 1:1 in the early age groups but rapidly increased after the age of 20, and for the period of 65

years and older was almost 7:1. Analysis of this age data by five-year periods revealed that these general age and sex relationships were consistent throughout.

Methods

The cases in the New Haven data of the man whose cause of death was listed as complete bisection after lying down across the railroad tracks, and of the woman who set fire to her own bed, were exceptional. The common means of commission of suicide were chosen by more than three-fourths of the subjects: hanging (32 per cent), asphyxiation by gas (22 per cent), shooting (13 per cent), and poisoning (12 per cent). Small numbers chose jumping from high places or drowning, and a very few chose death by cutting or piercing instruments, or miscellaneous means. In general, breakdown by age, sex, and trend, of methods of suicide chosen by the New Haven basic group, showed little variation from the national patterns for white persons.

Nativity

Of the 218 cases in the basic group, the place of birth was not listed in 53 cases (those for whom death certificates were filed during the period 1941-1943 only). Of the 165 cases where place of birth was listed, 34.5 per cent were foreign born. This was significantly higher than the 20.1 per cent of foreign born in the white population of New Haven, and this ratio was consistent throughout the 15-year period. The over-all average yearly suicide rate for foreign-born whites was 15.8, for native-born whites 8.2.

Breakdown by sex reveals however, that this relation held true only for males. About 42 per cent of all male suicides were among the foreign born, whereas only about 11 per cent of all female suicides were among the foreign born—although the percentage of foreign born in the New Haven general population is 20 to 22 for male and female groups alike. These hitherto unremarked facts—that the foreign-born:native-born suicide ratio is high only for males, and that less suicides are committed by foreign-born females than by native-born—held true in the New Haven data even with age adjustment. The ratio of male:female suicide rates among the foreign born was consistently about 10:1, almost four times the male:female ratio of rates among the general population (for all ages combined).

It should be noted that 39 per cent of the New Haven foreign born were born in Italy, 12 per cent in the Irish Free State, and about 10 per cent in other countries of predominantly Roman Catholic population (countries in which the suicide rates are very low).

Religious Affiliation

Because death certificates do not list religious affiliation, no exact analysis of the religious affiliations of the New Haven suicide cases is possible. However, there are certain indications in the available data that religious affiliation does not play an important part in suicide rates in New Haven—a conclusion which is consistent with the indications in recent literature that religious affiliation does not play an important part in suicide rates throughout North America (as has been previously noted).

A 5 per cent random sampling of all families in New Haven indicated that 56.9 per cent of the general population list their religion as "Roman Catholic." Local Catholic authorities have estimated that this is correct, and that the percentage of Roman Catholics is somewhat more than 57 per cent among the foreign-born whites, and slightly less among the native-born whites. Despite this fact (that there is a larger proportionate Roman Catholic group among the foreign born), the local foreign born had much higher suicide rates than did the native born, even with age-adjusted data, as has been shown. Also, despite the fact that New Haven has a percentage of Roman Catholics almost three times greater than the percentage in the entire United States population, New Haven suicide rates have been consistently equal to, or greater than, those of the general population of the United States. This holds true even when limited to age-specific rates for native-born whites. Thus it seems likely that the influence of Catholic affiliation on New Haven suicide rates is very limited. Of course no indication of the *devoutness* of religious affiliation is available.

Relation to Illness and Disability

When suicide is listed as the cause of death on a certificate, details relating to antecedent or contributory illness are seldom specific. In the basic group of New Haven suicides, over one-tenth of the total group of 157 males, and almost one-fourth of the total group of 61 females, were listed as depressed psychotics. Of the males, 5 per cent; and, of the females, 11 per cent were listed as

suffering from some form of mental disease not specifically designated as depressive—in most cases, schizophrenia or an unspecified psychosis. But 22 to 23 per cent of each sex were listed as suffering from "psychic depression," "simple depression," or some other nonspecific synonym signifying some sort of depressive reaction other than psychotic. In none of these cases with a postmortem diagnosis of nonpsychotic "depression" was the illness listed as severe or of more than one year duration, and in only a few was the duration of the illness listed as more than several days to several weeks.

Organic disease was probably listed only when a more exact antemortem or postmortem diagnosis was possible. Of the males, 20 per cent, and, of the females, 10 per cent, had listed on their death certificate some form of organic disease, although for only one-half of this group of males, and for only one female, was any indication listed that the organic disease named was severe or malignant or chronic. In most cases where an organic disease was listed, "depression" was also listed.

Further breakdown by age and GSE Group revealed no significant trends.

Occupation and Socio-Economic Status

When basic group data were classified by inclusive occupational categories, and were age-adjusted, the only statistically significant trends were the tendencies for males and females of the combined professional and business executive groups toward fewer suicides, and for females of the white-collar groups (many of them nurses) toward somewhat more suicides than would be expected from their percentages in the general New Haven population.

The relation of occupational status to suicide, however, should be accepted only *cum grano salis*. Regardless of statistical significance, there are several difficulties inherent in original classification which render occupational status of limited value as a measure of socio-economic position. First, occupational class designations used in coding suicide data, and those used in census data, are not really specific and discrete entities. The listing of occupation on death certificates is vague (and probably exaggerated in status in many cases). And some males and females were listed on death certificates as "dependents" or "housewives," designa-

tions which could not be used in determination of socio-economic statuses (as the occupation of parent or husband was not listed).

It was to be expected that a gross correlation of occupational status and socio-economic group exists, and on cross-checking this was found to be true. It should be noted that the numbers of business executives and professional people in the general population of New Haven are comparatively small, so that GSE Groups A and B (called the "upper classes" in this study) include in their largest percentages, white collar workers and skilled laborers. It is possible that the conclusions regarding the "upper classes" are in reality more valid for what is commonly termed the "middle class."

Fortunately, the *Neighborhood-District Plan* of New Haven made possible determination of gross socio-economic class of any local resident with knowledge only of his usual address. When such determinations had been made, data for members of GSE Groups A and B (the "upper classes"), and, similarly, data for members of GSE Groups C and D (the "lower classes"), were combined in order to increase statistical significance. In the basic suicide group, then, the "upper classes" were found to have an average yearly suicide rate of 12.3, and the "lower classes" of 8.0. GSE Group D had a rate of 6.2—much lower than that of any other GSE Group. These differences were all statistically significant.

But such differences might be accounted for on the basis of different age, sex, or nativity distributions in the various GSE Groups. (Race was not a factor: Rates were calculated only for white suicides in the white population.) The foreign born—with high suicide rates—are predominant in the "lower classes." And the percentage of males—with high suicide rates—is also slightly more in GSE Groups C and D. On the other hand, older age groups—with high suicide rates—are predominant in the "upper classes." But when the original rates were adjusted for all three factors: age, sex and nativity, the "upper classes" had an average yearly suicide rate of 12.1, which was significantly higher than that of the "lower classes"—7.8. And the lowest socio-economic class, GSE Group D, had a rate far below that of any other GSE Group —a rate of 5.3.

These were statistically significant facts: that the groups of lower socio-economic status, in the white population of New Haven, tended to have lower suicide rates than did the groups of higher

socio-economic status—and that the group of lowest socio-economic status had also the lowest suicide rate.

Sex-specific rates demonstrated that the male:female ratio of suicide rates in GSE Groups A-B was 16.4:8.6 (about 1.9:1) and in GSE Groups C-D was 12.6:3.2 (almost 4:1). Median ages at suicide were 57.5 for upper class males, 55.0 for lower class males, 48.5 for upper class females, and 42.5 for lower class females. Apparently suicide rates in the lower socio-economic classes were low for both sexes, but lower class females had extremely low rates, especially in the older age groups.

Table 2. Age and Sex-Specific Suicide Rates for Gross Socio-Economic Groups in New Haven, Conn., from 1936 through 1950.

Age in years	0-19	20-44	45-64	65 and over
Males				
GSE groups A-B	0.5	9.5	33.0	37.4
GSE groups C-D	0.3	9.2	27.3	65.1
Females				
GSE groups A-B	0.5	8.4	15.7	8.2
GSE groups C-D	0.2	4.3	6.4	7.2

Age and sex-specific rates are listed in Table 2. Although adjusted suicide rates for both sexes and all ages combined demonstrated a definite tendency to be lower in the lower classes, among males in the age group "65 years and older" suicide rates in GSE Groups C-D were markedly higher than those in Groups A-B! The data clearly indicate that suicide rates among lower class white males continue to advance in every age period and increase markedly after the age of 65, while rates for upper class white males increase only slightly in the age group "65 years and older." The higher suicide rates of upper class males exist only in the age groups under 65 years. (See Figure 1.) This reversal (in the older male age groups) of suicide rate relationship to socio-economic class was statistically significant; and, in general, these patterns were consistent in each five-year period.

Implications

The gross patterns of suicide among white residents of New Haven (who killed themselves in New Haven) are, in general, consistent with patterns of suicide among white residents of the entire United States. It is, therefore, likely that patterns determined

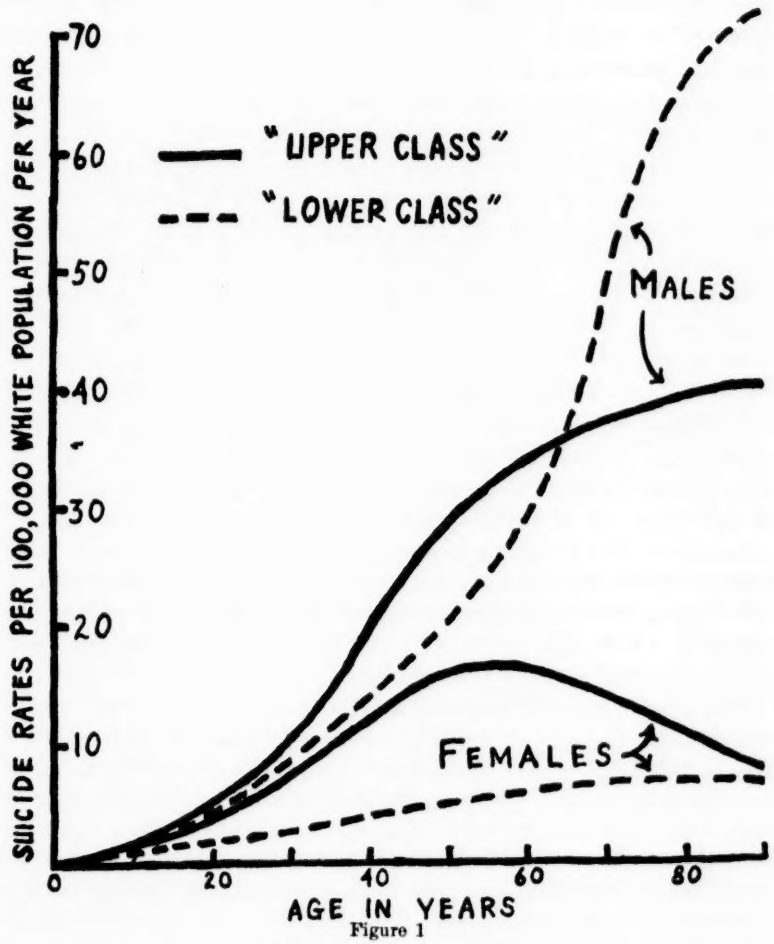

Figure 1

here in categories in which national data are unsatisfactory, missing, or confusing, will also be found to be valid for the country as a whole.

Probably the most important contribution of the present study is in the analysis of the relation between socio-economic status and suicide rates. The data indicate that corrected suicide rates for white residents of New Haven (excepting males 65 years and older) are consistently higher in the upper socio-economic classes. It

might be possible to account for this tendency on the basis of differences in religion. It has been noted that 56 or 57 per cent of the local population are of Roman Catholic faith. Catholicism as a basic factor could be considered, however, only if both of two suppositions were proved to be true: that New Haven Catholics have lower suicide rates than do non-Catholics, and that Catholics are more concentrated in the lower classes (which is probably so, although New Haven Catholic authorities did not confirm this second supposition). However, it has already been indicated that recent evidence elsewhere in North America and internal evidence in this study in New Haven do not confirm the first supposition.

Other reasons for the relationship might be that members of the "upper" socio-economic classes carry heavier burdens of responsibility; these persons may be more affected by fluctuating economic conditions. It may be that mores and taboos concerning suicide vary in the different socio-economic classes. Another possibility is that members of the lower socio-economic classes choose outlets other than suicide for their aggressive impulses—certain studies have indicated that homicide rates are inversely correlated to suicide rates, and homicides are more frequent among the lower classes.[7, 12, 14, 59] The importance of "psycho-social isolation" and socio-geographic mobility is not clear.

But suicide rates do increase markedly among lower class white males after the age of 65, whereas the increase in the rates of upper class white males in the older age groups is slight. Reasons for this appear more obvious: the older male of the lower class is very likely to undergo some degree of economic stress, and he probably suffers considerable frustration in his feeling of uselessness, his feeling that he is no longer considered capable of remunerative work. Such problems plague the lower class older male in much greater degree than they do his contemporary of assured income and position. Too, the aged lower class male who suffers organic disease is probably less able to stand the costs of medical care; his avocational interests may be more limited, and his family less tolerant. Geriatric rehabilitation has been accepted as a problem by mental hygienists[60, 61]—modified retirement programs, pension plans providing some degree of economic security, and stimulating social activities for the aged have all become more and more common—but the waste of life and social productiveness

which accompanies old age in our present-day culture remains a difficult problem.

Summary

Suicide rates, influenced by cultural attitudes, adverse external situations, and the basic psychological make-up of individuals, may be considered the mortality rates of a form of mental disorder ("hypereridism") which, though marginal and poorly defined, is essentially an ecologic process representing a reaction between host and environment. Valuable information can therefore be gained from epidemiologic studies of this disorder.

Review of the literature reveals that suicides in the United States occur in certain patterns. Those patterns have been analyzed in terms of trends; age, sex and race distributions; methods; and the influences of war, economic conditions, seasonal factors, heredity, nativity, place of residence, religious affiliation, marital status, illness and disability, occupation, and socio-economic status.

An epidemiologic analysis of 278 suicides in New Haven, Conn., from 1936 through 1950, reveals that gross patterns in New Haven are in general similar to those prevailing in the nation. In certain categories, the New Haven study adds important new or clarifying information. The most important contribution appears to be in the demonstration of a definite relation between socio-economic status and suicide rates (concerning which there is a dearth of fundamental data, especially in this country).

In general, members of the lower socio-economic classes had lower suicide rates than did members of the upper socio-economic classes. This was true even with age, sex, and nativity-adjusted data. (This relation was analyzed for white persons only, so that race was not a factor. There was no evidence that religious affiliation played any important part in suicide rates in New Haven.) Females in the lower socio-economic classes had extremely low suicide rates. Age-specific data, however, revealed that this relation of low suicide rate to low socio-economic class reversed itself for males 65 years and older: i. e., rates for lower class males demonstrated a steady increase in each advancing age period, but upper class male rates leveled after the age of 65, and in that older age group, rates for lower class males were considerably higher than

those for upper class males. These patterns relating to socio-economic status and suicide were consistent and statistically significant.

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INSTINCT OF SELF-PRESERVATION AND NEUROSIS*

BY SIEGFRIED FISCHER, M. D.

The terms love, affection, self-esteem, rejection, self-consciousness and insecurity occur frequently in books and articles on dynamic psychology and abnormal psychology, and often in psychoanalytic literature. It is proposed here to investigate the underlying principle of the dynamics connected with these concepts and their significance in neuroses.

One may choose as an example a relatively simple case of a neurosis.

Case 1

A man now 50 years old, came to this country about 12 years ago. He worked first as a stock clerk. As he wanted to become independent, he took a course in sign painting, a trade which he liked and for which he was qualified by natural aptitude, as well as through some training in art which he had had when he was younger.

As soon as he began to work as an independent sign painter, he suffered from nightmares almost every night. He would wake up in great fear, his heart pounding, and only after an hour or two was able to fall asleep again.

He also complained that he was constantly afraid of delivering signs to his customers, because he feared they would tell him the signs were not satisfactory or, even more important, would say there were better sign painters. Although he wanted to increase his business, he was afraid to ask a prospective customer for work for fear of being rejected. When he finally gathered courage to interview a new prospect, he was immediately discouraged if he was told that the proprietor was too busy to see him, or something similar. His fears became so great that, as he said, he sometimes played with the idea of "jumping off the bridge."

The history of the patient in brief was as follows. He was the second of five children. His oldest sibling was a sister. He had two younger sisters and a younger brother, Harry, who was born when the patient was six years old. In the second interview, the patient mentioned his distinct memory that, "When Harry was born I was pushed aside. Harry was the apple of my mother's eye and was favored by the whole family. Everybody bragged about him, how handsome he was and how intelligent. Nobody paid attention to me. Even my father made me feel that I was not as intelligent nor as good-looking as my brother."

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After he finished high school, he went to an art school for about a year. He then entered his father's store. At that time he already suffered from the symptoms described. He was afraid that his father or his customers would blame him for being inefficient, and, therefore, he lived in almost constant fear.

It is obvious that this patient's present suffering was caused by his childhood experiences. Let us first look at the fear from which he suffers today. According to his description, the fear was often unbearable. Sometimes it was so strong that suicide seemed to be the only way out. What was this man afraid of? Anticipation of rejection by his customers, or of being told that another man was better than he, gave him, in his own words, "the feeling of being worthless." And the feeling of being worthless is unbearable; it can be so strong that death appears to be a deliverance. Our patient, therefore, anticipated an impending unbearable danger when he foresaw that he might feel worthless.

Going back to the origin of his neurosis, we know that he was "pushed aside" by his family, and particularly by his mother, from the time he was six years old, when his younger brother was born, through the years of his later childhood and adolescence. His family made him feel that he was no good and, particularly, that he was not so good as his brother. He felt he was not accepted by his parents, as was his brother.

One can see that as a child the patient evaluated his own worth according to the way he was treated by his parents. The writer has pointed out in other reports,* that, *the child has no other measure of his own value but recognition.* In other words, independent of the actual value of the child, whether he is handsome or ugly, intelligent or stupid, healthy or crippled, he *feels* about his own value *only* according to the amount of recognition (time, affection and love) given by his parents. To mention only one example: Crippled children who usually get much attention and time from their parents, *feel* valuable despite their *knowledge* of physical inferiority.

What is termed *recognition* here is only what the child accepts as such. Recognition is, first of all, the amount of time we spend with the child; second, it is the interest we show the child during

*Fischer, Siegfried: Anxiety, insecurity and neuroses. Am. J. Psychother., 3:238, 1949. And: Principles of General Psychopathology. P. 238. Philosophical Library. New York. 1950.

this time by doing something with him which he enjoys; third, it is encouragement; fourth, it is the verbal approval the child receives; fifth, but not least, it is the affection we give the child.

In the writer's opinion, knowledge of the fact that the child has no measure of his own value other than recognition is a basic prerequisite for the understanding of children, as well as for the understanding of many neurotic patients. If a child does not receive the time, interest, attention and affection he needs, he does not have the feeling that he is worth while. Worse, he feels worthless. And the feeling of being worthless is unbearable. Therefore, the child has to blind himself to the feeling, otherwise he cannot go on living.

From Case 1, we also learn that the feeling of being worthless, which is created in childhood, is carried over to adulthood. When this occurs, a neurosis exists. The adult patient, despite knowing better, is not able to fight the feeling of being worthless, and he must adjust his whole life to this fact. The feeling of being worthless deprives the subjects of any self-confidence or self-assurance, and, as a consequence, of any real security. Feeling secure is *the* prerequisite of everything else in life. This is true of both human beings and animals, mature and immature. If a person or animal feels insecure, all other interests, and even other drives, disappear; if the feeling of helplessness or insecurity is strong enough, even the sex drive may vanish.

It seems necessary to clarify what is meant by the terms: feeling of security and insecurity. The person who is really adult feels insecure or helpless only when he is confronted with an actual danger to his life from which it is impossible to defend himself.* Just the opposite is true of many neurotic persons and of children; their feelings of security or insecurity are *not* based on any actual dangers existing in the external world. A very good example is the statement of a war correspondent who suffered from a neurotic feeling of insecurity. Once during World War II when he was under terrific bombardment, he looked at the tense faces of some officers and said smilingly to himself, "If they only knew what it is to try to cross Market Street in San Francisco." We can understand these feelings better when we think of the emotional

*It should however be remembered that the psyche of the adult contains protective devices which prevent excessively traumatic effects following emotional blows. See the author's aforementioned book, page 219.

reactions of children: A child walks with his mother in a crowded street and suddenly finds himself without her. The child becomes panic-stricken in a situation where no actual danger exists. On the other hand, his mother may take him in her arms and leap from the twentieth floor of a building in order to escape a fire, yet the child feels safe because he is in the arms of his mother. In the first instance, although there is no actual danger, the child is panic-stricken. In the second, the greatest danger exists, but the child is unafraid.

It is obvious that the child derives his feeling of being secure from the outside world through his parents or their substitutes. When the child feels that he is unprotected, whether an actual danger exists or not, he feels insecure. He derives his feeling of security from the same source from which he derives his feeling of being worth while. The same is true of many neurotic individuals. They too derive their feeling of being secure, as well as of being worth while, from other people, not from themselves as the mature adult does.

There are different degrees of the feeling of inadequacy, of inferiority or of being worthless. The basic quality, however, is always the same. Every child feels inadequate and consequently insecure when he believes he is not recognized or is not sufficiently recognized. The same is true of the neurotic adult who has carried over to his adulthood the open wound of the feeling of being of no value or of being worthless. *Each of these persons is afraid of being hurt again on the wound that was inflicted on him in childhood and that has never healed.* Therefore, he is careful and is alert for any possible danger, like a man with an open wound who tries to protect his injury from further harm. He watches so that it shall not even be touched again. In all these cases, the individual has the fear of becoming aware of being worthless or of thinking that other people might find him worthless (projection).

Whereas the child is helplessly exposed to such feelings, unless he makes himself blind to them and escapes in daydreams, the adult is not supposed to be dependent on the recognition of other people for a sense of his own value. *The diametric contrast between a child and an adult in this respect lies in the fact that recognition is vital, essential for the very life of the child. For the truly adult person, however, recognition, while pleasant and comfortable, is never essential to his life.* Recognition may be pleasant but it can

never change the feeling of the real adult about his own value. This feeling lies within himself. He has the feeling of being valuable when he fulfills his duty to the best of his abilities; and the opinion of others cannot change his feeling, unless he accepts a criticism as justified. Only neurotic people—who have not reached this adult stage because they were hurt in childhood—react like children to rejection (and more often to anticipated rejection) with fear and anxiety, and to recognition, approval and acceptance with relaxation. Recognition and acceptance not only cause a pleasant feeling in neurotics, but result in a feeling of safety and security as if, for the time being, they can go on living.

As a consequence in such cases of neuroses, we deal with a power that is much greater than any other drive, including the sex drive: namely, the drive for self-preservation.

Insecurity and helplessness, of course, may arise from other causes, but this discussion is limited intentionally only to the feeling of insecurity that results from the feeling of being not valuable.

Realizing that we are dealing here with the fear of annihilation, or on the other side of the coin, with the drive for self-preservation, it becomes evident why some people with such a background are shy, why they retreat and become self-conscious. It is also obvious why other persons develop such tremendous reactions as rebellion against everything and everybody, why they have a lust for power or are greedy for money.

The importance of this concept for the understanding and the treatment of some neurotics is exemplified in the short description of the following two cases, a compulsion neurosis in a woman and a case of exhibitionism in a man.

Case 2

An unmarried woman, 24 years old, had the following complaints: She felt compelled to wash her genital organs and anus for hours until she felt clean. Similarly, she was impelled to wash her hands frequently. She was panic-stricken when she was near any bottle that might contain alcohol because she feared she might drink the contents, become drunk and forget what she was doing. She was also in terror of contact with any bottle that contained acid or a caustic fluid for fear she would get it on her face and be hurt and disfigured. In such instances, she had to assure herself over and over again that nothing had happened to her. Her greatest fear was of losing control of her bowels and bladder, because if that happened she would be soiled and could never again feel that she was actually clean.

Both the patient's parents were of Italian descent. Her father showed no interest in her; he never had time for her and never was affectionate. She could not remember that he had ever kissed her. He frequently told his wife not to play with the children because that would spoil them. Her mother was always busy with the household and her many children. She was strict and the patient often heard her saying, "If you ever have anything to do with a man before you are married, you can never come home again."

From the age of 10 to 12 years, the patient frequently indulged in childish sex play with her brother, who was two years younger than she. Because this was, she said, the only pleasure in her very unhappy childhood, she continued the sex play, even though she felt extremely guilty about it. Although she realized that her parents knew nothing about these acts, the patient felt that she was neglected because of her bad behavior with her brother. At the age of 18, she kissed a young man, pressed her body against his and, although fully clothed, experienced a clitoral orgasm. From that day on, she felt extremely worthless because she believed she had gone against her mother's injunction and done the worst thing possible. Yet, at that time and through all the following years, she always had the hope that there might be a slight chance to gain the love and affection she had missed during her whole life. She believed this would be possible if she could be entirely clean and if she could keep her appearance from being spoiled by an irreparable physical injury. In other words, she hoped that if nothing else were added to make her *completely* worthless, she might still have a slight chance.

A few days after the experience just described, the patient began to have compulsive symptoms which developed more and more as time went on. She could not keep from cleansing her sexual organs, anal area and hands. She had to wash herself for hours. When she saw a car going by her window she was panic-stricken for fear it might injure her head and spoil her appearance so that she would no longer be acceptable. She was afraid of the electric light, of hairpins and, as mentioned before, of liquor. It became necessary for her to "check," over and over again to see that there was nothing near which could cause her injury.

The patient was first treated with electric shock by a private psychiatrist. When she showed further deterioration, he sent her to a hospital. She remained in the hospital for about 18 months, but became steadily worse, particularly after the following incident. She liked the doctor who treated her, except that "he never talked." One day she felt that it would help her in her distress if the doctor would show interest, in other words, if he would show that he accepted her. During an interview, she got up from her chair and put her arm around the doctor, wishing to be embraced by him, but the doctor did not move. The patient's immediate reaction was

that, obviously, he did not accept her. The apparent rejection increased her feeling of being worthless. About the same time, she received a further blow which resulted in a tremendous handicap in later treatment. She was told that the staff of the clinic considered performing a lobotomy, an operation which, to her, indicated that she would become worthless beyond repair. The idea of being forced to undergo such treatment haunted her for months. When she finally came to the author for treatment, she was in a desperate state and was so worn that she looked 15 years older than her actual age.

The patient was treated according to the following underlying principle. It was realized that she felt almost entirely worthless and lost because of a lack of recognition and acceptance throughout her entire childhood and adolescence. This feeling referred to her whole personality, as well as to her appearance. It had come to a climax after she had committed the act of embracing the young man, which, according to her mother's teaching, was unforgivable. In spite of her guilt, she still believed that she might lose this unbearable feeling, that she might be acceptable and accepted if she did not become more unworthy because of uncleanliness, physical or spiritual, or through an irreparable physical injury or disfiguration. To her, such events would have implied that she had reached complete worthlessness. In this case, she would have been entirely lost, or in her own words, "unable to go on living," without any hope. The patient, therefore, was striving to avoid the feeling of complete worthlessness or complete annihilation; she was fighting for her life.

In time, this patient lost almost all symptoms. She also found a young man who gave her much of the love and attention she needed. After she was practically cured, he married her, and, as far as it is known now, she is happily married. Whether her husband's love will continue to compensate for the lack of previous recognition, particularly for neglect in her childhood, is not known. Even if it does, the neurosis has not been entirely cured, since a husband's love certainly should not be needed to satisfy the childish wish for feeling valuable.

Although sex factors were involved in this case, they were not basic for the understanding of the patient's problems and were not important in her treatment. The dynamics became entirely comprehensible to the patient when she realized that her symptoms resulted from her feeling of worthlessness or, in the last analysis, from the drive for self-preservation. The more the patient real-

ized the effect of the injuries she had experienced in her childhood, and the more she felt that her worth today did not depend on the estimation of her mother, or on external sources, the more her condition improved.

Case 3

This patient, a 29-year-old happily married man, suffered from a tremendous urge to expose his genital organs to women, especially young girls. His pleasure was considerably increased if he masturbated at the same time. He imagined that he was providing a performance no woman had ever seen before. If the woman saw him and perhaps smiled or giggled, the climax of his ecstasy was reached, since he interpreted her laughing as approval and confirmation of the fact that he had shown her something out of the ordinary. As long as possible, he avoided an orgasm. Often, however, he continued exhibiting his genital organs after having had an orgasm. In explanation he stated that, "When I don't have any sex desire, I still have the tendency to exhibit, for instance, after I have had an orgasm. The sex desire only increases my desire to exhibit."

The patient had visited foreign countries while serving in the merchant marine, but had no urge to exhibit himself during this time. He remarked spontaneously that he felt so superior, because he was an American citizen, that the thought of exhibiting never occurred to him.

He daydreamed frequently of masturbating in front of a group of elegant and exquisite women who admired him for giving them a wonderful performance such as they, even though they were rich and had seen everything, had never encountered before.

The patient also suffered from another symptom which dated back much further than his tendency to exhibitionism. As long as he could remember, he had always been oversensitive to any slighting remark, particularly those referring to his physical strength. Whenever such remarks were made, he flew into a rage. Any comment, no matter how far-fetched, which could be interpreted as derogatory or humiliating caused the strongest resentment. He then indulged in daydreams and imagined that he attacked and hit his detractor. When he felt that his employer "looked down" upon him, he imagined setting the store in which he worked on fire. His favorite daydream, which, with some variations, he had imagined since childhood, was that of breaking out of prison after having attacked the judge who sentenced him and the policeman who took him there.

He always tried to impress people by showing off when he swam or ice-skated. Several times, he applied for a job as truck driver, a job which was for him, the symbol of strength.

A short time ago a dramatic change occurred in the patient's neurosis. He was promoted at work. Since then, he has not once thought of exhibit-

ing his sexual organs, even when the opportunity was offered; he has not indulged in his usual daydreams of revenge. Also, his outlook on life has changed entirely. The members of his family and the people with whom he works have remarked frequently that he has changed since his promotion and that he has lost his irritability and grouchiness. He himself was surprised at the complete loss of any desire for exhibitionism.

In brief, his history was as follows: His brother, who was four years younger than he, was always his "mother's boy," "the good boy," and the favored child. In contrast, the patient was always blamed by his parents, particularly by his mother. He was even blamed for the mischievous actions of his brother—because he had not watched him. His mother was never affectionate with him. The patient did not have much respect for his father. He grew up resenting his mother because she did not love him enough, and resenting his father because he could not protect him, as the father was, in the eyes of the patient, weak himself. At the age of 10, the boy's greatest wish was to grow up so that he could be independent of his parents. He was not interested in his schoolwork, fought against his teachers and did not care whether he was punished or not.

When he was 13 years old, his feeling of inadequacy was increased when another boy, on the occasion of mutual masturbation, said, "When are you going to grow up?" meaning that the patient's penis was not large. Shortly after this incident, he developed the impulse to exhibit his genital organs.

The sexual part of this patient's neurosis was only one branch of the whole neurosis. It is obvious that the *sexual* pleasure he derived from exhibitionism was of secondary importance. The important factor for this man was the need to be recognized, approved of, admired as valuable, primarily physically, but also in other respects. He had two ways of counteracting his feeling of being inferior; to imagine that he was admired, and to daydream of revenge and destruction. The latter was his way of saying, "If you don't accept me as I am, then I will be bad and tough, and outstanding as such."

For almost his entire life, this patient has fought to attain the *feeling* that he is good, as good as others. That is the main goal of his life. Because he had to battle over and over for this feeling, there was little energy left for the fulfillment of his daily duties.

When he was promoted at work, he found, for the first time in his life, recognition in reality. This gave him the feeling of being worth while. All his tendencies to gain recognition in childish and neurotic ways, in his imagination and through self-deception (in-

cluding exhibitionism), stopped automatically when reality gave him what he had craved his whole life. This certainly is not a cure, but it provides evidence of where the patient's real conflict lies.

In this case again, it is apparent that it was not the conflict with the sex drive that made this man unhappy, but his striving for self-esteem and self-preservation, a striving which was necessary because the feeling of being inadequate was intolerable.

This frustration originated in childhood when his mother did not give him a feeling that he met with approval or was as good as his brother. It was increased when other boys humiliated him for having a small penis. He carried this feeling of not being equal over to his manhood. The feeling of not being good enough, or worthless, was deeply integrated with the feeling of being insecure.

* * *

The feeling of insecurity may have other causes than those described here. But whatever the cause may be, its root is always the lack of satisfaction of the most powerful drive, the drive for self-preservation.

We now understand why a child needs recognition, love and affection and what it means to a neurotic individual to feel worthless and insecure. Love and affection are not only pleasant for the child, they are essential for his very life. And neurotics who feel worthless do not strive for pleasure but for something vital, for being able to go on living.

The Oedipus complex now appears in a different light. The desire of a son for his mother is not necessarily primarily sexual; it may not be sexual at all. The son needs his mother, first of all, in order to feel secure and valuable. The same is true of many neurotic patients. Such neurotic men want to have their mothers, so that they may feel safe and valuable through their mothers' protection, love or approval. It is true that in some cases a neurotic person wants to have sex relations with his mother. The deeper analysis, however, shows that it is not primarily the gratification of a sex desire that these neurotics anticipate, but the feeling of being accepted entirely. Sexual intercourse of the son with the mother would be the extreme proof that the mother loved him and that would make him feel secure and valuable. In such cases a fusion of two instinctive drives exists.

Summary

It is the goal of every uncovering method in psychotherapy to make the symptoms of a neurosis comprehensible through uncovering that of which the patient is unaware, which in most cases consists of childhood experiences. In three cases it was demonstrated that the symptoms became completely comprehensible by uncovering the feeling of being worthless and insecure, which was created in childhood by the patients' parents. All three patients felt worthless because they did not get the recognition they needed from their parents.

The child—in diametric contrast to the mature adult—has no measure of his own value, other than recognition. Recognition is *essential for the life* of a child, whereas it is pleasant, but never vital, for the mature person.

On the basis of these observations, the Oedipus complex appears more of a tendency to gain security from one's mother than to satisfy a sexual desire.

It is also shown here that therapeutic effects can be accomplished by applying this theory without emphasizing sexual problems; that is, by making the neurosis comprehensible through comprehension of the power of the instinctive drive for self-preservation. It is true that, in at least two of the three cases described, strong sexual problems were involved. The proportion might even be greater in a greater number of cases. We have to assume, therefore, that in such cases a fusion of two instinctive drives exists. At the present time it is not entirely clear why this fusion exists, and what the relationship is between these two drives in neurotic individuals. For purely practical purposes, however, it seems possible to base the treatment of such patients exclusively on the theory of the instinct of self-preservation and to deal with the sex problem as of secondary importance.

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HOSTILITY AND PSYCHOTIC SYMPTOMS*

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Introduction

The purpose of this paper is to report evidence for the view that the symptoms in schizophrenia are an attempt to internalize certain severely hostile impulses. This connection, between psychotic symptoms and intensely hostile impulses, has received increasing attention in recent psychiatric literature. As early as 1911, Freud[1] in his "Case of Paranoia," interpreted the persecutory delusion as an inner hatred which had been transformed by projection. Others who have noted this phenomenon include Abraham,[2] Sullivan,[3] Fromm-Reichman,[4] Knight,[5] Rosen,[6] Standish, Mann, and Menzer,[7] and Bychowski.[8]

The present writer also has been impressed, both by the regular appearance of these intensely hostile impulses during therapy, and by their relationship to the psychotic symptoms. These hostile feelings appeared as a characteristic pattern in each of six schizophrenic patients who were treated with individual, intensive, analytically-oriented psychotherapy. They arose from within each patient, since they were quite disproportionate to any situational frustration at the time. Further, they were kept in a latent form by the manifest psychotic symptoms, since their emergence was intimately associated with the weakening of the latter by psychotherapy. This relationship of hostility to manifest psychotic symptoms will be discussed more fully following details concerning selection of patients, technique of therapy, and case histories. Only the hostile impulses, among the various factors associated with psychotic symptoms, are considered here, in order to focus attention on a limited area.

Description of the Study

The Patients

Six male patients residing on the continued treatment ward of the male service of the Bedford Veterans Administration Hospital,** who had been uninterruptedly psychotic for at least two years were

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chosen for therapy. Accordingly the symptoms of the patients were sharply outlined and relatively fixed, rather than vague, shadowy, and fleeting as seen in borderline and acute psychoses. Every patient in this series was less than 31 years old, since it was felt that relatively youthful individuals, despite a long continued illness, would retain greater elasticity and capacity to respond favorably to therapy than would older chronic patients. All the patients had been diagnosed as having schizophrenia but they were of diverse sub-classifications, two hebephrenic; two paranoid; one catatonic; one unclassified type. A diversified group such as this was selected so that features common to schizophrenia rather than characteristic of a single sub-type might be noted.

The Therapeutic Program

The technique of therapy was varied in order to adapt to the different problems encountered in treatment. The approach toward each situation was derived from the following over-all considerations.

1. Therapy was based on psychoanalytic theoretical principles; that is, the concepts of a dynamic unconscious and of transference phenomena in the doctor-patient relationship were employed.

2. This was primarily an insight type of therapy. It was assumed that the patients would gain more from an awareness of what was behind the presenting symptoms than from support or attempts at repression. Accordingly, special attention was focused on the affective and behavioral changes which occurred in the patients when their initial symptoms fluctuated in response to the therapeutic intervention. The doctor-patient relationship was the principal instrument for altering the psychotic symptoms.

3. Other psychotherapeutic devices in addition to insight were employed as indicated. For example, the therapist used positive counter-transferences to convey as positive and friendly an attitude toward the patients as was consistent with a dignified doctor-patient relationship. By this means, the therapist sought to mobilize whatever capacity the patient had to form a friendly relationship, to avoid overtaxing his ability to co-operate, and to keep his anxiety on a level, within bounds which he could tolerate. Other methods such as suggestion, reassurance, and guidance were also employed. For example, if the patient refused to appear for a scheduled interview, the therapist would go to the ward and at-

tempt to overcome his reluctance by tact and persuasion. Usually, the man had failed to appear because of his anxiety. When this occurred, his anxiety was immediately explored during the therapeutic session, or if he persisted in refusing the interview, the therapy would be discontinued for a day or two and resumed when his anxiety had lessened.

4. Interviews were held daily with each patient in the vis à vis situation and were usually an hour in duration. Variations in this schedule were allowed when indicated by the patient's emotional state or by the need to integrate therapy with ward duties. Thus if the patient was extremely disturbed at the end of an hour, the session would continue until he quieted down. Similarly if he was still expressing important material the therapist would postpone termination of the interview. On the other hand the interview might terminate in 15 minues if the patient was in an apathetic or unproductive mood or if any emergency situation occurred on the ward.

* * *

As mentioned previously, these therapeutic principles were used to cope with the special problems presented by these regressed patients. Uninterested in their environment, seething inwardly with conflict, intolerant of anxiety, they might soon have abandoned a form of therapy which depended upon a greater measure of their co-operation and persistence under emotional stress. That this method was successful may be attested to by the fact that daily therapeutic sessions continued from four months to two years, despite the formidable obstacles which arose.

The patterns of hostility which appeared during therapy and their relation to the manifest psychotic symptoms are illustrated in the following case histories.

Case Histories

Case "A"

History. "A," a 27-year-old man, was admitted to Bedford Veterans Administration Hospital, in August 1948, with a diagnosis of schizophrenic reaction, hebephrenic type. A life-long history of emotional disorder was noted, for even at six years of age, his teachers described him as "timid and fleeing from reality." In 1942, after a year of military service, he became hallucinated and acutely psychotic. He received a medical discharge from the army on February 26, 1943, with the diagnosis of "dementia præcox."

In May 1947, he was admitted to Cushing Veterans Administration Hospital in connection with a suicidal attempt. There he failed to show improvement after a course of 60 insulin shock treatments. Following transfer to Bedford, he became unkempt, mute, and negativistic except for transient verbal periods following three courses of electric shock.

Therapy. During July and August of 1950, daily "interviews" were held with him in an effort to overcome his mutism. However, it was only in September, while in the midst of another series of electric shocks, that he began to respond verbally to the therapist. It developed that he remembered the earlier visits in spite of his previous mutism. This encouraged the therapist to continue treating him.

His initial coldness, evasiveness, and withdrawal diminished markedly in repeated interviews in response to a friendly attitude on the part of the therapist and to gifts of cigarettes which "A" accepted at first furtively, but later with increasing avidity. At the same time, he became tense, and began to express delusional fears about women in general and his mother in particular. A repeated idea was that "women go together in groups," and that they ignored him and his needs. He also spoke of a plot, among women employees at a factory where he had been employed, to cheat him of money and to keep him from having a good job. He further believed that he was to be "sent to the electric chair" for having "dealt with mobsters," and that he was likely to be "beaten up," "raped," or "murdered."

As the therapist repeatedly identified these persecutory delusions as projections and encouraged the patient to verbalize further about them, "A" gradually became aware of his associated latent hostile fantasies. Since, by this time, his initial apathy and reserve had been somewhat reduced, he now expressed his inner antagonisms and hatreds with a marked affect which had previously been lacking. Some of these resentments were expressed in relation to the therapist. Indeed, he spoke of wishes to make the doctor vanish into nothingness, to cause him to drop dead on the floor, to murder him, or to smash him as he would a balloon. Furthermore, he began to tear up his clothing frequently while on the ward, and he became prone to outbursts of verbal abuse against ward personnel. Despite his increased irritability and apparent discomfort, he tolerated the interviews better, smoked more freely, and verbalized more easily and coherently.

His overt hostility reached its most intense pitch when his long-held delusion that he was a woman disappeared in response to therapeutic intervention. His firm belief had been that he had no penis, that he had instead a vagina, breasts, and a woman's clothing—that in short he was a female. In order to explore this idea, he was encouraged in the first place to express his feelings about feminine and masculine attributes. In the material, which emerged only with frequent hesitations, he expressed repeatedly his feeling that women were "weak, harmless" creatures and the

recipients of much attention and love. Men, on the other hand, he felt, were aggressive "racketeers" with great powers to murder and destroy and were decidedly unloved ones. He displayed a great deal of feeling, not only in regard to his fears connected with masculinity, but also in his wishes for the gratification and security which he associated with femininity.

This delusion of sexual inversion was gradually weakened by the repeated ventilation of his associated ideas during therapy and by the lessened need for defense against his inner hostile feelings, which he could now verbalize within the therapeutic setting. Accordingly, his initial flat pronouncement that he was a woman now changed to a tone of uncertainty and to expressions that he merely wished to be a woman. He also was showing, along with his hostile affects toward the therapist, some positive feeling—as could be seen by his readiness to appear for interviews and by his responsiveness and co-operation during these sessions. Noting these changes, the therapist now felt secure in taking his second step, which was to assure "A" repeatedly that he was in fact a man, that he could verbalize his aggressive feelings without acting them out, and that the therapist preferred that "A" accept himself realistically as a man.

"A" finally responded by surrendering his delusion of being a woman, although, meantime, he manifested enormous overt anxiety. Now his reddened cheeks, angry glare, dilated pupils, and hateful vituperation contrasted markedly with his initial cold withdrawal and tight emotional control. Following this point in the seventh month of therapy, his overt hostility, both in interviews, and on the ward waned steadily, and he cautiously and gradually became more friendly.

Meantime, he became relatively bright and alert in the interviews, his ideation became much more realistic and his former delusions receded, so that most are now forgotten or recognized as "imaginations." Nevertheless residuals of bizarre thinking are still discernible. He has not relinquished his idle, institutionalized mode of living; his appearance, though improved, is not yet satisfactory; and finally he shows no ambition or drive to return to the community.

Case "B"

History. "B," a man of 23, was transferred to Bedford in April 1950 from a state hospital, where he had been for eight months. He had been considered to be a fairly well-adjusted person previous to discharge from the navy in 1946. After return to civilian life, he became markedly apathetic, asthenic, and erratic in his attempts at work. Despite electric-shock treatments he became progressively more hallucinated and deluded until he was transferred to Bedford.

In the early interviews, which began in July 1950, he evidenced minimal overt anxiety, but was extremely apathetic, unresponsive, and silly. Many

of his expressions were quite incomprehensible; others included neologisms such as "dope-disease," and hallucinatory and delusional material such as "radio voices speaking to me," and "televistic influences."

Therapy. The therapist persistently encouraged him in daily sessions to verbalize and to respond with more seriousness to questions. Two months elapsed, however, before he changed perceptibly. He then became much more aware of the therapist's presence and began to speak more relevently and coherently. At the same time that he became more responsive, he manifested increasing tension and discomfort in the interviews and began to express vivid paranoid material with a marked affective display of fear and hostility. He glared furiously, flushed, and strode about the interview room, too restless to sit down, as he accused the therapist of keeping an "electrical influencing machine" in the desk, and of being allied with a gang of persecutors who were shooting electric rays at him, threatening him with incarceration as a criminal, and intending to dope or to murder him. On the ward he changed from a giggling, inoffensive patient to an overactive, disturbed individual who had to be transferred on October 4, 1950 to a seclusion room on the acute service, because of assaultiveness toward an aide. Fearful and extremely hostile to the therapist during the next few days, his clinical picture cleared strikingly in the following week, for he became alert, responsive, intelligible, coherent, and even friendly. When the doctor inquired about "B's" former delusions, "B" spoke of them as a dreamy, hazy memory of the past which he now disowned. Furthermore, "B" now recovered his ability to discuss realistically details of his past life at school, in the service, and in his home.

Buoyed with a feeling of accomplishment, the therapist arranged a transfer to an open ward. Within the next few days "B" showed increasing discomfort, becoming tense, depressed, evasive, and hinting at a wish to run away from the hospital. With increasing tempo he reverted to a full-blown psychotic state in which once more he was talking about "dope in the milk," "a mob beating me up," "being a dirty crook," and "electrical influences."

As his fantastic beliefs returned, his affect changed from gross discomfort to satisfaction, and indeed to a mild elation. However, his verbalizations did not become as bizarre as they had been at the beginning of therapy. He continued to express persecutory ideation, but with much less anxiety than he had earlier.

Many antagonistic and sadistic wishes now emerged, together with much fear and tension as he verbalized further about his persecutory fears. He felt that he had murdered people with "illegal guns," and that he might "blow up the hospital with an 'ammunition dump.'" He also expressed punitive wishes about the therapist, although with marked apprehension and hasty apologies. Indeed, "B" repeatedly balked at verbalizing his

anxiety-laden hostile feelings, attempting to avoid the subject by means of wordy, fanciful harangues on peripheral topics.

His evasiveness led to a fluctuating clinical course, similar in pattern to the one already described. The over-all trend, however, has been toward more mature thinking and behavior as his hostility gradually spent its force. Initially he was either in a regressed, vegetative state or else was extremely disturbed. Now he is relatively alert, pleasant, and responsive; he converses more realistically, although he still evidences grossly psychotic ideation.

Case "C"

History. "C's" first signs of mental illness occurred while serving in the army, where he was hospitalized for several months before transfer to Bedford Veterans Administration Hospital in 1945. Previously he had been reserved and aloof in manner but a "model child" and a "brilliant" college student. His mother attempted to keep him at home but failed because of his irritability, increasing persecutory expressions, and threatening behavior. He received a complete course of somatic therapies including lobotomy but failed to sustain improvement with these measures before he was rehospitalized at Bedford in August 1948.

Therapy. Treatment began in August 1951. At the time he spoke haltingly and evasively, but demonstrated a clearness of contact and an ability to recount the history of his illness which were in sharp contrast to his bursts of delusional ideation. Too restless to sit down during most interviews, he would walk around, peering suspiciously into the dictaphone, staring out of the windows and frequently cocking his head and making a defiant side remark as if responding to auditory hallucinations. Persecutory trends were the major element at this time. He insisted that he was being "punched and beaten," that the therapist had him at his mercy and was "taking him for a ride." He thought there was a plot to kill him, that the therapist was the chief conspirator, and that the secretaries were listening in and collecting reports about him. Considerable antagonism characterized his affect in the early interviews, but this overt hostility increased markedly as the therapist pointed out that actually he was attempting to help him, not to persecute him. Indeed, continuation of treatment became extremely difficult because of his increasing hostility which was accompanied by marked tension and overactivity. Nevertheless, the interviews continued with a show of firmness and tact on the part of the therapist; and, in the meantime, "C's" hostility mounted to an extremely intense pitch. At the beginning of November, in one interview the patient actually started toward the therapist, his face contorted with rage, demanding a fight. However, he promptly became submissive, depressed, and apathetic after having apparently been overcome by his antagonistic

wishes. Thereafter his hostile expressions waned steadily in duration and intensity and he became co-operative, responsive and more realistic in his thinking.

In mid-November he went into a quiet, depressed phase, where less hostility was evident. He appeared melancholic, and announced "I am backward, worthless." "I have led a bad life." "I once killed a bird." "I once punched a playmate in the nose." After two months his depression cleared, and was replaced by a continuing kind of neurasthenic reaction. His attitude toward the therapy gradually changed. He became interested, co-operative, indeed eager to see the therapist.

His mother reported improvement in his behavior on week-ends with her. His previous hostility diminished markedly, and he was calm, relaxed and, indeed, pleasant and friendly. For months he maintained ground privileges, and his interviews with the therapist and a consulting psychiatrist were to a striking degree free of delusional and hallucinatory material. Nevertheless, he proved quite unwilling to make any substantial change from his idle, institutionalized adjustment. In October 1952 his hostility and persecutory expressions returned in less severe degree, apparently as a reaction to an unavoidable reduction in interviews, suggesting that the therapy so far had not succeeded in fully releasing his hostilities.

Case "D"

History. "D," a 30-year-old World War II veteran, was admitted to Bedford in May 1950. The record of his illness dates back to 1945, when he became seclusive and complained that men were calling him "a homosexual."

Thereafter, he was hospitalized repeatedly and treated with courses of electric and insulin shock with slight transient improvement. While outside the hospital he spent much time at police agencies, protesting that he was not mentally ill and at the same time seeking intervention against "accusations" which he heard leveled at him wherever he went.

Therapy. The early interviews in May 1951, were rather productive, since "D" was alert, responsive, and quite ready to verbalize. Initially he expressed much persecutory ideation, accusing the therapist together with others, of attempting to deprive him of freedom and attempting to hurt and to punish him. As he verbalized some of these feelings, his affect changed. Previously, despite some hostile outbursts, he had been on the whole fairly well composed. But now, he became overtly anxious and more hostile. His antagonism included among its targets the therapy itself. Many times he refused point blank to see the therapist, or else stormed furiously out of the consultation room before his time was up. He also attempted to block therapy by ridicule, by a determined silence, and by protestations that talking was foolish and unnecessary, but these de-

vices were unsuccessful, since his pressure of speech did not allow him to remain silent for more than a few minutes. He began spontaneously to express anxiety-laden material, and his final recourse was often flight from the interview.

The therapist attempted to maintain a friendly composure and to refrain from pressing him. When he became over-anxious in an interview and demanded to leave, the therapist did not insist that he stay. Therapy was suspended several times for periods of two or three days in order to allow "D's" anxiety to abate. At times the interview was conducted during a walk about the grounds when "D" was too restless in the interview room. Despite all attempts to cushion his anxiety, "D's" agitation increased markedly. He trembled visibly, perspired freely, blocked often in his speech because of his struggle with his feelings, and appeared increasingly uncomfortable in the interviews. In June he left the hospital without permission and thereafter had to be transferred to a more closely-supervised ward where his treatment was continued.

Besides attempting to keep rapport with him, the therapist also tried to deal with the persecutory ideation, which was the main trend in his thought at the time, especially as this presented itself in the therapeutic relationship. Rather than hurt him, the therapist's role was to help him—this was the main theme with many variations as "D" poured out his accusations. These confrontations met with some success, for the persecutory tone diminished markedly. It was replaced with a mounting animosity, accompanied by increasing anxiety, as "D" aired his hostile feelings toward his parents, the government, and senior hospital administrative officials, as well as toward the therapist.

Meantime, "D" grew increasingly uncomfortable as his inner hostile feelings emerged with the weakening of his persecutory beliefs. Often he would impulsively utter a threat or a destructive wish with intense feelings. Immediately afterward—quite overcome with anxiety—he would arise, pace about, perspire, look about fearfully, denounce the therapy and demand to leave. The therapist was unsuccessful in his attempts to moderate "D's" anxieties. Four months after the onset of treatment, "D" stubbornly and persistently refused to sit down with the therapist in the interview room so that treatment terminated in mid-October of 1951.

Case "E"

History. "E," a 26-year-old man, was admitted to Bedford Veterans Administration Hospital in August 1949, by transfer from a private hospital, where he had been treated for eight months for schizophrenia, mixed type. In his 'teens he had been shy and unusually sensitive to criticism, but frank symptoms of mental illness were first noticed when he was in military service. In 1944 he threatened to kill a junior officer in an army

camp, and also wrote threatening letters to members of his draft board. He was medically discharged in 1944, with a diagnosis of "psychoneurosis," having narrowly averted a court-martial. During the next several years, he was idle, seclusive, and "dreamy" at home. In January 1949, he was admitted to a private hospital following an angry outburst against his mother.

Therapy. In the early interviews, "E" usually sat pre-occupied in a stony silence, dismissing questions with a shrug or else replying curtly "that does not seem worth answering." It was only in October that he began to respond with some degree of freedom. His first expressions involved chiefly his persecutory fears, "When you see the patients laughing hysterically you wonder," "Some people here are dumb enough not to know that somebody is laughing at them behind their backs," "Some patients here run around as if they are checking up on me in order to run to the doctor with damaging stories." Meantime a degree of resentment and suspicion appeared in his attitude instead of his former coldness, apathy, and withdrawal. The material continued to the end of 1951 to be mostly persecutory in tone, but, in the meantime, he was expressing his own hostile feelings in a tentative and gingerly fashion.

He asserted that despite his bland exterior he had "more violence in me than the truculent and aggressive patients around here." His earlier evasiveness toward doctors, he ascribed to a fear that they mean to "probe me for homicidal impulses." With some feeling, he dwelt on his conflict in the army which trained him to kill, while at the same time he had an internal struggle to control his own violent impulses. "The men in an infantry company want to kill each other." "The urge to kill can mount so high that one can be a menace to the group." To help him tolerate these feelings, the therapist repeatedly emphasized the distinction between one's wishes and one's behavior, assuring "E" that his behavior had been good and would continue to be so.

As "E" became more voluble, he also became more tense and anxious. He expressed his persecutory and hostile ideation with increasing agitation and affect. He spoke of having been "eaten alive" on one building, and having been "killed" on another. His acting out at first involved tearing up his own clothes. When, in his increased upset, he threw a cigarette into another patient's clothing, he was transferred to the acute service. This ushered in an extremely stormy period for "E." For several interviews, he trembled visibly in an extreme rage. His pupils were dilated wildly, his face flushed, and his tone of voice violently antagonistic as he voiced the belief that he was hated and detested by all the doctors at the Bedford hospital, as no one had been hated before. His mother reported that his excitement resembled the one which had led to his initial hospitalization.

His disturbance continued in a fluctuating fashion for several months. Meanwhile, he was periodically hostile and paranoid, and at other times, strongly depressed. He involved himself impulsively in several altercations with other patients. The interviews were continued, but somewhat irregularly since he was in a distant building. In general his disturbance had spent a great deal of its force, when his ward physician suggested a course of electric shock, which was given in July of 1952. He responded rather well, becoming noticeably relaxed, alert, and pleasant in his manner. His thoughts became more realistic and much freer of paranoid ideation and hostility—as a result, apparently, of both the psychotherapy and the electric shock.

Case "F"

History. "F," a 29-year-old, married veteran, was admitted to Bedford for the first time in 1951. A quiet non-aggressive person during his 'teens, he had developed an acute psychotic reaction while serving in World War II. He had repeated periods of remission of symptoms but at other times heard imaginary voices making derogatory remarks about him at home and at work. He was impulsively assaultive, and remained continuously hallucinated and overactive for many months before treatment began in the fall of 1951.

Therapy. A supportive and expectant type of therapy was planned at first because of a possibility that he might soon be returned to the community. Accordingly the doctor sought to achieve a friendly relationship with him, but avoided confronting him with his numerous persecutory beliefs or encouraging him to verbalize further about them. "F," however, became acutely anxious at this time in connection with his wife giving birth to another child. He became resentful and screamed aloud at his relatives. His tone of voice changed to an overwhelming fury, his face became livid, his pupils dilated, and he eyed the therapist with extreme suspicion, meantime accusing him of being another persecutor. The therapist transferred the patient from his own ward to the acute service, where the interviews continued despite "F's" extreme tension and suspicion.

The therapist now became more active, since he felt that a serious effort should be made to help "F" rid himself of some of his conflictual feelings, instead of allowing them to subside without some resolution. Accordingly the therapist pointed out to "F" repeatedly his unrealistic feelings, meantime encouraging him to verbalize further about them. "F" remained in a disturbed affective state, manifesting marked overt hostile feelings associated with much tension. The persecutory beliefs which he now expressed differed from those at the beginning of therapy. Earlier, they had remained the same in content from day to day and had been expressed fairly calmly, but now they became quite unstable as his hostile feelings were increas-

ingly verbalized. His doubts were manifested by his tone, by periods when he agreed that his beliefs were quite unrealistic, by a frequent shifting in the content of these persecutory ideas, and by periods of defensive overreaction. Thus, at times he would assert his delusions loudly and would feel them so keenly that he was dissuaded only with difficulty from striking other patients on the ward, who, he thought, were "like a bunch of vultures ready to pounce on me." In his agitation he experienced gastrointestinal distress apparently associated with his anxiety.

His tension abated gradually, however, over a period of several months. He ceased having auditory hallucinations, and, indeed, was able to discuss these as ego-alien, imaginary experiences of the past. He became more realistic in his over-all mental content. He spoke quite freely in interviews and reached a level where he was much more agreeable, relaxed, and in better contact than he had been before admission to the hospital.

Discussion

It is evident from these case histories that the symptoms in schizophrenia are adaptive in nature; that is, they function to keep latent certain intensely hostile impulses which otherwise would become overt and give rise to markedly unpleasurable affects. The importance of these aggressive feelings in schizophrenia was clearly demonstrated by the regularity of their appearance in each case, by their characteristic intensity, and by their patterns of inter-relationship with the symptoms during therapy. It was clear that they stemmed from within the patients, since they were quite inappropriate to the actual situation during therapy.

These hostile feelings were liberated in each case as the symptoms were affected by therapy, and they were expressed with increasingly violent affect in relation to contemporary figures, including the therapist. The presence and intensity of this hostility was evaluated clinically, that is in terms of the patients' apparent tension, their agitation, the threatening tone of their speech, and their mental content of extreme antagonism. Patient "D" was still increasingly hostile when he caused his treatment to be discontinued. The five others experienced this period of extreme negative feelings between the third and ninth month of therapy but continued with treatment nevertheless. The similarity of this pattern as it appeared in successive patients was all the more impressive since such common features were otherwise lacking among them. Thus, one notes that patient "E" had been silly on initial examinations, "A" had been apathetic, "C" and "D" moderately

hostile; "E" and "F" had been verbose; "A" and "D" almost mute. "A" and "E" did not immediately present persecutory ideation, whereas the others did in varying degrees; "F" expressed more delusions of reference than did the others.

By contrast, a dramatic resemblance among the patients was apparent in the extreme rage which each experienced after several months of therapy had elapsed. In connection with the intensity of this hostility, one is reminded of Freud's prediction that "We are much more likely to find the simpler assumption sufficient; that the instincts are all qualitatively alike, and owe the effect they produce only to the quantities of excitation accompanying them."[9]

The defensive nature of the schizophrenic symptoms was evident from their changing patterns as intensely hostile feelings emerged. Thus it is noted that at the beginning of therapy, when delusional and hallucinatory ideation was most firmly held, or when the patient's withdrawal from interpersonal contact was most complete, "free-floating" hostility was at a minimum. On the other hand, increasing overt hostile feelings and anxiety were manifested when the patients became uncertain or vacillating about their fantastic beliefs, or when they became more responsive to people about them, including the therapist. The maximum degree of overt anxiety was usually reached when a previously-held psychotic symptom-complex was no longer apparent. At this point, the patient would usually be overwhelmed with anxiety and would exhibit intense rage spells.

Thus it can be seen that a progressive instability or diminution in symptoms is correlated with an increase in overt hostility associated with marked anxiety. On the other hand, this relation was reciprocal in nature; when decreases in overt hostility occurred during psychotherapy, they were accompanied by increased prominence of symptoms. This pattern developed, both gradually over periods of weeks, and more abruptly within individual interview sessions.

Further confirmation of the defensive nature of the psychotic symptoms was apparent in the clinical picture which appeared after these hostile feelings had remained overt for a period of time and then diminished within the therapeutic situation. The patients then exhibited relative relaxation, improved ability to re-

late to people, and more realistic thinking. These changes toward maturity seemed possible then because the dissipation of the hostile feelings had relieved an internal pressure and lessened the need for such extreme forms of defenses as psychotic symptoms.

Many other changes, occurring during therapy, were illuminated by viewing the symptoms as adaptive in nature. For example, "A," "D," and "E," manifested increased overt anxiety, as their initial apathy, silliness, and withdrawal were counteracted by the continuing and strengthening therapeutic relationship and the encouragement given to their verbalizations. Accordingly, this manifest anxiety was understood as resulting from the weakening of a defense, the retreat into autism. Persecutory delusions in all these patients, and in addition the delusion of being a woman in "A," now became prominent. These false perceptions and beliefs again faded in response to the therapist's attitude, tone, and confrontations. Again the anxiety which appeared in association with the emerging hostile impulses was understood as resulting from the weakening of a defense. Furthermore, the tenacity with which the initial morbid beliefs were held now became more comprehensible because of the related inner turmoil revealed by the psychotherapy. The patients were spared the extreme psychological discomfort associated with experiencing their latent affects, as long as their delusions, hallucinations, and psychotic behavior were prominent. Accordingly, they attempted to deal with their internal anxieties by retaining stubbornly their psychotic symptoms, disabling as these were. The therapy thus became more meaningful with the aid of this orientation.

Many further questions arise here. Why should these schizophrenic patients have such intensely hostile feelings? What is their source and genesis? To what extent were these hostilities dissipated in the foregoing cases by psychotherapy? How can therapy best be designed to release such impulses? What is the connection with libidinal impulses in schizophrenia? Would these same findings recur with varieties of schizophrenia not represented in these cases? To discuss such questions is beyond the scope of this report, which is concerned only with the view that symptoms in schizophrenia are an attempt to keep unconscious a reservoir of intensely hostile impulses.

SUMMARY

The view that schizophrenic symptoms are an attempt to keep in a latent form certain intensely hostile impulses, is examined in this study. It is supported by experiences gained in intensive, individual, analytically-oriented psychotherapy with six schizophrenic patients.

The principles governing therapy and the relevant case history data are described.

The patterns of response which recurred regularly during therapy and were considered significant are noted as follows:

Particularly severe, hostile feelings appeared progressively as the symptoms seen in the early interviews receded with therapy.

When the symptoms reappeared prominently during therapy, the overt hostility diminished.

After hostility became overt and dissipated within the therapeutic situation, the symptoms were lessened considerably.

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PSYCHOANALYTIC OR DIDACTIC GROUP PSYCHOTHERAPY?

BY J. W. KLAPMAN, M. D.

In group psychotherapeutic circles, analytic and didactic forms of treatment are designations which have taken on categorical values. Yet a more careful appraisal may disclose that only a polarity exists in a place where distinct categories were apparently discerned.

Something in the way of definitions is naturally in order. By didactic group psychotherapy, is to be indicated that mode of treatment which more or less preponderantly places reliance on an expository or explanatory approach to treatment. By analytic group psychotherapy, is indicated that mode of treatment which places its greatest reliance on the exploration of the instinctual-affective forces and their vicissitudes, with a view to releasing or eliminating the retarding factors which have prevented the usual, natural, or "normal" emotional development, such therapy being conducted along the approaches outlined by Freud and his adherents.

The easiest criticism to make, and the one usually offered, of group treatment, a criticism designed to indicate the paucity of valid bases, is on the score of the great variety of modes and methods employed in group psychotherapy. The implications here is that should sufficient data ever accrue, only one method—the method—would emerge from it. If this objection is characterized as very superficial, there is good cause. Individual psychotherapy, which is presumably much older and better established, has not evolved one method and only one. There are, for example, techniques of suggestion, persuasion and exhortation. There are the methods of hypnosis and narcoanalysis and psychoanalysis, etc., etc.—surely not one single mode of therapy. Nor is the multiplicity of methods thus encountered in itself an indication of lack of knowledge or data. Actually, it is not a question of which one method is *the* best. The question is, rather, which method, which instrumentality and which combination of modalities is most likely to be effective with the particular patients to be dealt with. It is also to some extent a question of which modality the therapist can best work in, by reason of training, aptitude and character structure.

It would appear most probable that with the cruder, more poverty-stricken personalities the more didactic methods will be more

promising initially; and for patients of greater attainments the more intricate and complex approaches are indicated—and still one rarely encounters a patient who, despite considerable academic achievement, does not labor under some misapprehensions and misconceptions and who cannot benefit from some didactic approach. Therefore, any objection based on the apparent multiplicity of methods is certainly ill-founded. Future problems to be studied may include the elaboration of even more techniques and, at the same time, a careful search for and clear definition of the indications for the use of the various modes of therapy. That this will eventuate, is suggested by the careful, even fastidious, selection of patients for psychoanalysis by its practitioners.

There must, therefore, be approaches designed to enrich and condition personalities from the more primitive levels so that they may become amenable to higher psychotherapeutic techniques. One reason many patients are not amenable to depth psychotherapy is that the matrix of the personality, as it were, is too poverty-stricken; and one may postulate that didactic group psychotherapy has as one of its objectives the conditioning and repleting of the areas other than those concerned with the instinctual-affective elements of the personality.

From this point of view any possibly conceivable controversy between analytic and didactic group psychotherapy can be regarded as fatuous. The kind of group psychotherapy to be resorted to in any particular instance is not determined solely by its inherent properties, but also by the particular conditions encountered: the types of personalities to be dealt with, the level of psychopathology, the life situations of the patients involved, and so on.

Because psychiatry originated as a medical specialty it retains a strong affinity with the somatically-linked components of psychological functioning. It consequently does not feel at ease with the non-physical, or psychological, components of personality functioning. Even psychoanalysis has not entirely escaped it; and thus we reach a new dichotomy consisting of the emotional and intellectual. That which attempts to reach, mend or improve the intellectual component is minimized, and, in fact, derogated. But the emotional! That is considered, par excellence, the avenue or medium of treatment.

But it requires no great depth of observation to note that what happens in the group of the skillful pedagogue is not solely a mat-

ter of exposition and explanation. How often is it said of an instructor or professor, "He certainly knows his stuff, but he just can't teach." And conversely many will recall some statement about some academic light, that perhaps he was less erudite and not so distinguished scholastically as might be, "But he certainly puts the stuff across and is a wonderful teacher." Learning, it is becoming increasingly clear, is not a process of passive absorption, and what happens in the class of the skillful pedagogue is a process akin to transference in psychoanalysis.

This point has been touched upon by Powell, Stone and Frank[1, 2] in the following: "Education and therapy are complementary phases of a single process—the *Learning* process as directed to the achievement of effective maturity. The extent of their identity has been obscured by their more salient differences in emphasis: the one upon mastery in the handling of *Judgments,* the other in the handling of *feelings.* By an oversimplified aphorism, one could say that education teaches the individual how to examine *what he thinks* about what he feels is important; therapy, to examine *how he feels* about what he thinks is important. The process with which both are dealing is that which intervenes, within the human organism, between the stimuli it receives and the responses it makes. It is the process which translates a stimulus into a perception and directs the individual's response—not to the stimulus, but to what it has become, to what he thinks it is. This process runs the gamut from somatic responses below the threshold of awareness, to experiences clearly perceived, conceived, and verbalized. Philosophy and education have given most of their attention to the latter and of this gamut; psychiatry, growing at least partly out of medicine, has given most attention to the other parts of it. The effectiveness of individual action may be lessened by inappropriate responses of feeling; these are, for psychiatry, related to each other in a dynamic universe of emotions. Or action may be distorted by inappropriate judgments; and these, for the philosopher, are related to each other in a logical universe of ideas."

It may be seen, then, that psychoanalytic and similar so-called deep therapies can be applied only, figuratively speaking, to top levels of personality functioning. This appears to be true also with their group therapy homologues. Thus, Wolf[3] carefully prepares his patients for analytic group psychotherapy, and this de-

spite the fact that the preparation has come through individual psychoanalytic treatment over some length of time. The latter procedure would appear to be a reversal of the natural order, for in the writer's opinion group therapy, and especially didactic group psychotherapy, is the more logical preparation for individual treatment, although it is effective in its own right. Didactic group psychotherapy thus becomes a treatment for the masses, not only because of the reduced costs made possible in this way, but also because it is one of the best ways yet known to effect such a conditioning and reconditioning of the personality as to make possible deeper exploration and deeper therapies; it is ideally suited to effect such preparation.

That is not to say that didactic group therapy is solely preparation. It can in its own right achieve improvements and possibly some cures. There is, naturally, considerable overlapping. It is a question which instrumentality is most suitable with the particular group of subjects to be dealt with.

What marks the present writer's approach to group psychotherapy as being didactic is the fact that it is textbook-mediated. The textbook furnishes a continuous flow of stimulus material and, besides its other advantages, entirely eliminates the possibility of arid or silent periods. That does not mean that the patients' own productions and abreactions are ignored, for any group member is free to interrupt at any time and make whatever observation, exclamation or abreaction occurs to him. With unspontaneous and withdrawn patients such as chronic schizophrenics, this can be especially effective in drawing them out, for the contents of the book can hardly fail to titillate some aspect of the personality. Contrary to what may seem objectionable at first glance, in the use of textbook-mediated group psychotherapy with markedly regressed psychotic patients, it is this very medium which confers an advantage unobtainable, to the author's knowledge, by any other means; for, with the use of a textbook and the possibility of being called upon at any time to read aloud, even some of the most regressed and withdrawn are forced to pay more attention and remain more alert and active than by any other mode of approach known to the writer.[4, 5, 6, 7, 8]

It may be questioned whether any kind of force can possibly be therapeutic, but, empirically, the writer can only conclude from his observation that some degrees and kinds of coercion are salu-

tary, and are sensed by the patients as an evidence of interest on the part of the therapist and of some kind of concern for their welfare. With more spontaneous patients, the subject-matter may be even more successful in touching off reminiscences, comments, digressions of various kinds and various forms of group interactions. The therapist further amplifies and analyzes, expounds and explains. Digressions are embarked upon and followed as long as they have any relevancy to the purposes of group psychotherapy. In addition, there are relatively few individuals, aside from psychiatrists, psychologists and other trained professional workers, who will not derive some new orienting or re-orienting outlook from the material contained in the book. Some sample chapter titles may suggest the nature of the book's contents: I—Introduction; II—What Price Shame?; III—How It Began; V—Ingredients of the Mind; VII—The Basic Mechanism—Repression; XVI—Case History; XXIV—Further Observations on Mental Machinery; XXV—Something About the Process of Thinking.

The books are distributed at the beginning of the session and collected at the conclusion of the session. During the period, the therapist calls on various members of the group to read aloud. After a passage has been read, the therapist may ask, "And what do you think about it?" Any other class member may make comments and observations.

And still, the two—didactic and analytic group psychotherapy—are not so wholly divorced from each other as may appear at first glance. They are not so incompatible as might be suspected, and much the same objective may be attained by either road. The specific pathways, as stated, should be chosen to suit the various pedestrian capacities of different individuals. Freud himself (Collected Papers, Vol. 1) has had a much larger purview within his theories and their application than many of his followers have credited him with, stating, "Any line of investigation, no matter what its direction, which recognizes these two facts (transference and resistance) and takes them as the starting point of its work may call itself psychoanalysis though it arrives at results other than my own. . . ."

In so-called orthodox psychoanalytic therapy, repressed content is brought to the surface, aerated, ventilated and abreacted in a flow of productions known as "free associations." The importance of, and emphasis upon, "free associations" resides in the fact that

they presumably offer a method by which the patient's mental content is brought to the surface as it actually exists in the patient's mind, and is not distorted by the interference of the therapist. But one must surely ask: "How free is free association?" At the least, the analyst, through his training, sifts out the significant and potent productions and leads the patient along the pathways indicated by them, and thus gives some direction, however inconspicuous. The skillful analyst might be said to manage a maximally free association, but rarely, if ever, one that is entirely free. Therefore, by means of a psychoanalytically-oriented didactic group therapy, which takes the factors of resistance and transference into account, which is not mediated through peremptory orders and impositions, which takes into account the other multifarious influences that impinge on the personality, there eventuates a kind of psychoanalysis, which as far as methodology is concerned, employs associations which are not so "free" as in more orthodox psychoanalysis, being more in the nature of "directed associations."

It is true that the "directed associations" of didactic group psychotherapy are slightly different qualitatively from those in regular psychoanalysis. Much of the "directed associations" are educational or re-educational, but the central principle is still the same. The variation is made necessary by the patient's original state of unpreparedness for deep psychotherapy, and is justified on the grounds that psychological medicine has fairly well established the rationale for such direction and has sufficiently grounded the science of psychodynamics to make deductions from such "directed associations" of highly probable validity. They are justified, also, in that presumably the therapist is more conversant than the patient with a way of life more in harmony with the highest precepts and those replete with the greatest satisfactions in life.

Even for this point of view we find some authority at the fountainhead of psychoanalysis. Quoting from Freud, we find:

"In quite a number of cases . . . the analysis divides itself into two clearly distinguishable stages: in the first, the physician procures from the patient the necessary information, *makes him familiar with the premises and postulates of psychoanalysis, and unfolds to him the reconstruction of the genesis of his disorder as deduced from the material brought up in the analysis* [italics the writer's]. In the second stage the patient himself lays hold of the

material put before him, works on it, recollects what he can of the apparently repressed memories, and behaves as if he were living the past over again."[9]

Making him "familiar with the premises and postulates of psychoanalysis" is actually the prototype of didactic group psychotherapy: and from this vantage point, didactic group psychotherapy can be defined as the first stage of psychoanalysis, expanded and slightly modified.

Again, quoting from Freud: "The analyst finishes a piece of construction and communicates it to the subject of the analysis so that it may work upon him; he then constructs a further piece out of the fresh material pouring in upon him, deals with it in the same way and proceeds in this alternating fashion until . . . one lays before the subject of the analysis a piece of his early history that he has forgotten, in some such manner as this: 'Up to your nth year you regarded yourself as the sole and unlimited possessor of your mother; then came . . .' and so on."[10]

How didactic a role even Freud conceived psychoanalysis to have may be seen in the following: ". . . *as a teacher* [italics the writer's], as a representative of a freer and more superior philosophy of life, and as a confessor, who through the continuance of his sympathy and his respect imparts, so to say, absolution after the confession. . . ."[11]

At any rate, it may be contended, then, that the apparent categorization suggested by the division into psychoanalytic group psychotherapy and didactic group psychotherapy does, in fact, denote no actual categories, but a polarity of therapies. For, if the didactic therapy be sufficiently well-oriented to sound psychodynamic concepts, it must then remain a moot question whether such treatment, wherein the factors of resistance and transference are recognized and reckoned with, as well as catharsis, abreaction, objectification, etc., etc., all more or less worked through or "lived through," all under the aegis of a didactic regimen, does not accomplish the desired objectives in suitable selected cases.

Summary and Conclusions

Psychoanalytic and didactic group psychotherapies are not actually distinct categories. Which type of therapy is to be employed depends mainly on the mental status of the respective patients. Didactic group psychotherapy applies maximally to that vast res-

ervoir of patients initially unsuitable for deep exploration; and it therefore is, in part, a preparation for such depth therapy, although it can in its own right effect many deep restructurizations of the personality. The recapitulation and replica of these phases of psychotherapy actually obtain in regular formal individual psychoanalysis, for as Freud has stated: ". . . in the first [stage] the physician procures from the patient the necessary information, makes him familiar with the premises and postulates of psychoanalysis. . . ." This, the first stage of psychoanalytic therapy, expanded and enlarged, is the essence of didactic group psychotherapy.

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THE PROCESS-ORGANIZATION OF PSYCHOTHERAPY

BY CHARLOTTE BUHLER, PH.D.

Introduction

The following study on *psychotherapy success* and *treatment termination* grew out of discussions of a group of psychotherapists who, regardless of their differing backgrounds and schooling, agreed on the importance of a greater clarification of these problems.*

This study centers, as did the discussions, around the problem of treatment termination. A *model* or skeleton frame is suggested which is intended to represent the process-organization of any complete psychotherapy. Premature or timely termination is determined by the phase of the process in which it occurs. *Criteria of successful and of failing procedures* are tentatively formulated.

Some possible misunderstandings must be eliminated before they arise: This is *not* an attempt to determine the factors *responsible* for treatment success, nor to establish *how* success is achieved. This is *only* an attempt to establish the *structure* of the therapy process, if there is such a thing as an organically developing procedure.

In the panel discussion of the original draft of this paper, Marmor and Hooker accepted the idea of the skeleton frame, provided that certain precautions were observed, such as: not to let it appear as if phases in this process could be set off from each other by demarcation lines (Marmor); and to consider that this might be a frame for certain types of procedures only (Hooker). Futterman and Travis, however, seemed dubious regarding the possi-

*The discussions took place in the Los Angeles Society of Clinical Psychologists in Private Practice and led in June 1952 to a symposium. Participating as discussants in this symposium were, besides the author, the two psychiatrists and psychoanalysts, Judd Marmor, M. D., and Samuel Futterman, M. D., and the two psychologists, Lee Travis, Ph.D., and Evelyn Caldwell Hooker, Ph.D. In the present formulation of this paper, the comments of these four and of many other discussants from the floor, were gratefully considered as far as it seemed possible to do so within this frame.

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This paper is a first outline of ideas that will be discussed more extensively in a book, *Explorations in Psychotherapy*, now in preparation.

bility of setting up any general frame, as they felt the process in each case was entirely—individually—different.*

The author agrees that each case is, in respect to most details, individually different. But inasmuch as a restructuring psychotherapy may be called an organic growth-process, it seems to show some of the general characteristics of all growth-processes regardless of individual variations in detail, and regardless of the diagnostic picture—which was left out of this structural discussion entirely.

This then brings up the question of what would and would not belong in this type of a frame. A skeleton frame is made up of formal characteristics with no regard to specific contents of a process.

The fact that certain types of mental illness (for example an obsessive-compulsive neurosis) usually require a very much longer treatment period than others (for example, a conversion hysteria) and the fact that transference and resistance offer much greater difficulties in the first than in the second type of illness, need not effect the general frame.

Similarly it can be said that the different depth levels at which different therapeutic procedures operate need not influence the frame of treatment. That is to say, as long as a treatment achieves what Alexander so aptly calls "corrective emotional experiences,"[1] and as long as a personality is restructured to any degree, the skeleton frame obtains, regardless of the amount of unconscious material that is produced and of the depth at which the patient's conflicts are worked through. No one has shown this in a more enlightening way than Alexander.

Undoubtedly, different types of therapy emphasize different factors; and individual therapists may work from different angles. Travis emphasized in discussion, for example, the therapeutic relationship as the almost exclusively decisive factor. Other therapists may feel that the emotional impact of the therapeutic relationship varies greatly with individual patients. The psychoanalyst of the more traditional school will consider a transference neurosis an essential point in his procedure, while Alexander defines and uses, as do other neo-Freudian groups, a transference relationship which aims at producing "corrective emotional experi-

*This report is made with the speakers' permission.

ences," rather than the re-living of the earlier neurotic development.

All these are differences which need not change the frame of therapy. It is likely that from the point of view of these different schools of therapy, one or another criterion of successful or failing procedure would be added, omitted, or altered. If a transference neurosis seems to certain groups to be of the essence, they will add a criterion with reference to its successful development and resolution. From a more general point of view, it would seem sufficient that a positive therapeutic relationship be established and become an impact in the situation. More specific prerequisites belong in subgroups of this main criterion.

Undoubtedly, there will be workers in the field of psychotherapy who will not be able to see any usefulness in the attempt to find a general frame or model for a process of so great variety. But there is sufficient evidence that others feel very much the need of a conceptual clarification in a field that up to very recently seemed almost like an impenetrable jungle—or like a territory left to the ministrations of cultists, rather than of scientists.

The *hypothesis* of this study, then, is: A complete psychological treatment is an organized process, the phases of which can be related to phases of the patient's progress in rebuilding himself. Criteria of successful steps, as well as of failures, can be found all during the process. Premature or timely terminations are determined in relationship to the whole process. The successful treatment-process in the strict sense is considered a growth process, as its phases seem to show parallels to the human development phases, as discussed by this author previouly.[2]

Definitions

Three kinds of psychotherapeutic techniques are distinguished according to *goals* and *methods* employed:

1. *Supportive Therapy.* The goal of this is behavioral; but coincidental to this, there may be personality changes in certain areas.

The *methods* are encouragement of the patient's free expression of his problems, the providing of cathartic relief; reassurance and guidance in respect to inadequacies and problems that the patient cannot cope with: discussions meant to clarify issues and to improve attitudes; and manipulation of the environment.

Result of supportive therapy can be behavior improvement, solution of problems, symptom removal.

2. *Restructuring Psychotherapy with Limited Goals.* This type of therapy aspires to a personality reorganization to defined limited degrees.

It is a type of treatment belonging to the category described by Fromm-Reichmann as "intensive psychotherapy,"[3] and by Colby as "psychoanalytic psychotherapy."[4]

The methods are, as Colby points out, a combination of conversation and associations. The association technique is used to handle resistance and a transference-relationship in ways similar to those described by Alexander and his collaborators in his earlier studies on brief psychoanalysis. Interpretations are given, and essential personality changes are expected to be achieved by the patient's insight into his own motivations.

The degree to which this is done probably varies greatly with different therapists. Also views are still in flux regarding *how* and *when termination* is indicated in this type of treatment.

3. *Psychoanalysis* is the third type of treatment with the *goal* ideally of a complete restructuring of the patient's personality and with the exclusive *methods* of free associations and interpretations.*

Treatment termination is, in the three types of therapy, determined by somewhat different considerations. The supportive therapist's criterion is behavior improvement; the psychoanalyst's criterion is the completion or near-completion of personality restructuralization. The criterion for the therapist who restructures with limited goals is not easily named, and the procedure may seem more arbitrary and less determined by its internal structure than in the two other cases. The process-organization, as described in this study, applies essentially to the type of treatment by restructuring with limited goals. Psychoanalysts may take exception to the idea of the fourth phase of treatment, as indicated in this model, while the supportive therapist may feel that his procedure has no such definite structure as postulated here.

*This three-group division corresponds to a certain extent to that given by Robert P. Knight in: An evaluation of psychotherapeutic techniques. Bull. Menninger Clin., 16:4, July 1952.

Plan and Material

An attempt will be made here to demonstrate that *the process-organization of a complete treatment leads through five phases.* These phases represent the *Gestalt* of the process. The longer and deeper treatment leads the patient at a slower pace *through* and *deeper into* the process, but its structure is essentially the same. The present discussion will be devoted mainly to restructuring treatments with limited goals.

The data offered for discussion are derived from a study of 125 cases treated by the author in the last five years.* These cases are studied qualitatively and quantitatively with respect to a number of facts, among which is treatment-termination as related to results obtained and checked in follow-up studies.

The *termination* of treatments can either be *satisfactory according to plan* or it can have occurred as a *premature disruption.*

Since the question of *financial reasons* for premature terminations is often raised, some figures may be of interest. In the sample of 125 cases, 16 discontinued treatment in early phases, in complete resistance to the idea of personality changes; 32 discontinued it in later phases prematurely, unable to resolve their deeper conflicts at that time; four had to leave town.

In 10 of the 32 cases, *financial* reasons were offered as responsible for early discontinuation. Since however in all of these cases arrangements were suggested that would have made continuation possible, it follows, and can be shown, that in reality reasons other than financial were responsible. This, of course, does not mean that financial considerations can ever be unimportant. But if sufficient thought is given to the problem at the beginning, and if estimates of time and costs are made fairly accurately, financial problems can occur later only under special circumstances.

The idea of the following study is *to work out criteria for what can be considered a satisfactory goal-limited termination, as against a disruption of treatment.*

*It may be expressly stated that all cases were either referred by physicians or were under medical care during treatment. Several cases were referred by psychiatrists, and a considerable number were treated under psychiatric supervision or with frequent consultations with psychiatrists.

Two Groups of Criteria

Two groups of criteria are offered. The first refers to the *status* of a case at its termination, the second to the *structure* of the process.

The first main *criterion* is that in goal-limited successful cases *certain conflicts* have been resolved to the degree that some personality restructuring has taken place—sufficiently for the patient to grow on from there; while in the disrupted case an *impasse* has been reached.

Madeleine F., 26, whose husband had died two years previously, and who lived with a married man who had separated from his wife, had reached the impasse that she could neither resign him nor her Catholic faith which forbade this relationship as well as a marriage with this man. "I am too weak to be good," she said sententiously, "and too afraid to be bad."

The hysterical paralysis of her legs from which she suffered was an exact expression of the impasse that she had already reached before the treatment and that she could never overcome during treatment.

Questions might be raised as to whether this could have been overcome eventually. The patient discontinued treatment because she felt entirely unable to get any further at this point.

She later tried other therapists, hoping for help that would detour her conflict, but could not find it. Environmental, educational, and economic factors were also unfavorable in this case.

Dolores H., 29, had had a convulsion during toxemia at childbirth. She recovered, but from then on repeatedly had convulsions. In several neurological and EEG studies, no organic basis could be found for these disorders and the diagnostic impression finally was that the organic pattern was used by this patient hysterically.

In the ensuing psychotherapy, Dolores worked successfully through her childhood and marriage problems. She overcame the impact of her mother's rejection as well as the repetition of the rejection by her husband's family. But she reached an impasse when pressed by her husband to consent to her sterilization, because her life had been endangered and her child had been still-born and she had been advised by the physicians in charge that this was advisable. She interpreted her husband's attitude as another rejection which she was unable to accept. She broke off treatment, declared it was "no use," reverted to her fainting and convulsion spells and asked for physical rather than psychological help.

Charles R., a 59-year-old business man who had taken increasingly to heavy drinking for two years, was found to have used this escape after realizing that his younger business partners were over-riding him and calling his ideas old-fashioned. He successfully worked through his life history,

discovering that ever since his father's early death, when he supported his ailing mother, he had become accustomed to be domineering and in authority, increasingly so while he built up a fairly important business out of the smallest beginnings. But he reached an impasse when he realized he should resign himself to a secondary role now, or to what he considered a premature retirement. He was unable to accept this and relapsed into alcoholism.

However, two years later, this man returned to treatment and concluded it with a different attitude and apparent success as far as his drinking was concerned.

With these three, may be compared three other cases in which the solution of certain conflicts has been achieved.

Martin B., 25, had returned from the Pacific war theater with a tropical disease one and a half years before treatment. He had been unable during all this time to find his way back to health and into civilian life. He went on suffering from fatigue, vague pains and headaches long after the tropical fever had abated. He also was very depressed.

It was soon clear that Martin felt unable to face life and business at the side, and under the eyes, of an overwhelmingly superior father whom he had idolized all through his childhood, but who appeared now as a menace and not as the helper he always before had seemed to be.

Martin was able to work successfully through his relationship with his parents. After eight months of treatment he was not only free of his symptoms, but felt capable and eager to stand on his own feet.

It was realized from the start that there was probably a latent homosexuality problem in the picture. But since Martin's marital relationship with the young wife he had married one year previous to psychotherapy improved considerably with his general improvement, and since he was eager to start work in another city where he had located a position for himself, the termination of treatment at this point seemed justified, as it was assumed that with the changed father-son relationship, the adolescent homosexual tendencies might clear up.

Follow-up contacts of three years have justified this expectation.

Pamela M., 28, suffered from psychosomatic heart trouble and feared she, like her mother, would die from a heart attack.

She was well able to work through her ambivalent love and hate feelings toward her mother and her equally ambivalent relationship with her father. Her mother, whom she had idolized as a small girl, had neglected her for boarders whom she had had to take care of, and Pamela had wished in her jealousy and hatred that her mother were dead—hence her terrific guilt feelings and her identification with her mother's illness. In eight months she was not only freed from her symptoms, but had a different attitude toward life.

She felt able, and wanted to try, to clarify for herself her relationship with her sister whom she envied for having two children while she herself seemed unable to fulfill her wish for a child. She well understood the origin of her tendency to feel discriminated against, stemming from her childhood experiences with her mother.

Four years of follow-up contacts justified the decision to consider the case as finished with limited goal achievement.

Mortimer G., a brilliant engineer of 26, had come close to a "breakdown" over the difficulties he encountered at work in his personal relationships with his superior at the same time that his marriage proved to be a complete failure and was about to break up.

In therapy, he worked slowly but successfully through an intensely unhappy childhood in which he felt rejected by both parents and through which he went in loneliness with ever-increasing difficulties in his relationships with people, substituting satisfaction in mechanical and academic activities for a nearly non-existent socio-emotional life. Friendship with one other young man and sex relations with an aggressive co-ed came relatively late in college, followed by marriage with the co-ed.

In 21 months, Mortimer developed confidence and pleasure in his relationships at work where in the meantime he had been placed in a superior position which required much skill and tact in the handling of people. He had worked on his marriage problem and had come to the conclusion that this relationship was basically wrong and should be dissolved. He left the therapist with mutual consent that he was able to attack the problem of new social relationships and a new marriage on a different basis without further help.

In this case, there was, however, at the termination, the understanding that possibly the patient might need and want to return for another period of help at some later time, which he did one and a half years later, shortly after his divorce was final.

It is suggested that a legitimate termination of treatment may be defined as one in which the patient's outlook on life has changed; his understanding of himself and of others has developed considerably; and *essential blocking conflicts have been resolved* sufficiently for the individual to develop further from that point and be able to function more adequately.

Between the two situations of legitimate termination and disruption of treatment, can also be found the situation of *erroneous termination* on grounds of misjudgment of what has been achieved. This is likely to happen with patients who give the appearance of deep insight into their problems and failures, but whose understanding remains on the level of intellectual appraisal. In the

combined desire to please the therapist and to register progress, they press forward without really ever penetrating into their inner selves. While increasing experience will help the therapist to recognize, to establish and to handle this situation for what it is worth, erroneous termination probably occurs in everyone's earlier experience with short-term treatments. The following criteria of successful progress may be useful for the comparison of superficial with deeper-penetrating processes.

As *disrupted* treatments were distinguished previously from those *finished* according to plan, one must also distinguish treatments with *symptom removal* only.

While views on treatments with symptom removal only are still at variance, the prevailing tendency of our time is to favor restructuring treatments wherever they can be achieved.

The following case is quoted as an example of treatment failure and disrupted termination, as the achievement of symptom removal was considered only a temporary success which had to be interpreted as due to resistance to treatment and resistance to insight.

Dana, a 17-year-old girl, took what Freud called a "flight into health" in showing a miraculous improvement of her fatigue, headaches, poor school work, quarrels with parents and friends, within a few months during which she fought psychotherapy continuously. She even dieted successfully and lost 15 pounds. She so dreaded all attempts to lead her to an understanding of herself that she preferred to behave in well-adjusted fashion for the time being.

"What more do you want from me, Dr. B.?" she asked triumphantly in her last hour when it was decided to leave her for the time being to her triumph.

The unsuccessful treatment, the disrupted and the satisfactory treatment terminations can be related to different preceding process-organizations, and, with this, one comes to the *second group of criteria,* the events that *foreshadow* satisfactory and unsatisfactory conclusions.

The process-organization of the complete case is seen in *five phases.* In introducing these, two points are emphasized. One is the fact that these phases are, of course, *not* conceived of as separate periods or entities of any sort. The term "phases" is used to point out certain progress-steps of the process, in giving a summarizing account of what happens first and last.

However, there *is* some further meaning attached to the concept of phases as used in this connection. In studying development during psychotherapy, the process-organization appears to be very similar to that of *growth-processes.*

This idea as such, that is, the comparison of therapy with a growth-process, is nothing new. In fact it has been noted by many authors. However, beyond this general parallel, it appears that the *actual structure of the therapy build-up* resembles those five phases of development that were identified and described in the author's previous studies on "Human Life as a Psychological Problem."[2]

A very brief summary must suffice to indicate some relevant findings of those earlier studies. Biological, biographical and interview material was used to outline a model of the structure of human life. A sequence of psychological attitudes was paralleled to the sequence of growth- and reproduction-phases. In quoting the re-edited rather than the old version of the theory,[5] life is conceived of as a creatively expansive order-increasing process. That is to say, the living being tends not only to perpetuate itself, but also to impose its own order on the surrounding world. In the course of its own growth and decline, the individual transmits its structure-creating tendencies to the surrounding objective world and to its offspring which carries on where the individual has to leave off. From human beings we know that this reaching beyond their own existence, in contributing constructively, is what they "believe in," that this is what they are "living for." They "live for" accomplishing certain things which they bring forth from themselves as products, as well as "objectives" of their existence. This "self-realization" they prepare in phases in which they make contact with the world with which they will interact gradually, first in tentative, later in definite, relationships, goals, activities. After a satisfactory self-realization, the "contented" and "fulfilled" individual is ready to detach himself from life.

Therapy as a Growth Process

The complete psychotherapy process appears to have great resemblance to a growth process that leads from the initial contact with the therapist, through "corrective emotional experiences" (Alexander), to the fulfillment of a new form of existence and detachment from the process and therapist.

The model of a five-phase concept which seemed practical for a structural understanding of the growth-process and life-process, appears equally useful here in this attempt to structure the therapy-process. The five phases of therapy are these:

(1) There is first a period of *exploration* during which the *problem* and the *relationship* between therapist and patient are established in a preliminary way.

(2) There follows a second period in which the patient *probes deeper* into certain *conflict areas,* with *beginning insight* into the significance of his experiences and his attitudes.

(3) The central, third phase of the treatment leads, if successful, through the decisive corrective emotional experiences to the *discovery of the decisive pathogenic conflicts, the understanding and resolution of which enables the patient to reorganize his experiences of the past and his outlook on the future.*

(4) In the fourth phase, the patient *integrates* the experiences of his treatment into a new image of himself and the world, and *relates himself* in a new way to *fulfillment.*

(5) In the terminating fifth phase, the patient *detaches* himself from the therapist and both *dissolve the dependency relationship.*

Therapy Phases and Criteria of Progress

A number of criteria* of the successful traveling through of these phases can be found and compared with signs of failure in unsuccessful treatments.

Phase 1. In a successful phase 1, the *therapeutic relationship and the benefit of catharsis become effective reasonably soon after the beginning,* that is to say any time from immediately to about four months (*Criterion* 1.) Patient and therapist alike know then that a process has set in.

Everyone who does psychotherapy has had the experience of patients telling right after the start, even sometimes at the moment of having made the decision to start, that they feel better already, knowing they have turned over their problem to someone they feel will help them. Admittedly, however, it is at times difficult to ascertain that this process has as yet set in. On the other hand, therapists are well aware that they must not mistake the "transference cure," as Alexander calls it,[1] for anything else than a good beginning.

*Not all of which have to be included for the process to be successful.

If in two to four months a satisfactory relationship and the experience of relief have not yet set in, it is usually doubtful that they will, even if the patient is consciously determined to obtain therapy. An example of this unsatisfactory situation will be given later, in comparison with a long-resistant, but actually responding, case.

Phase 2 is started successfully if the patient *begins to take over* in contributing material, working on it himself, trying to penetrate it (*Criterion* 2). The patient in this phase also begins to *accept interpretations,* if the therapist offers them adequately.

The patient's taking over is a very important point. Especially in cases with strong initial resistance, the therapist will watch for the moment when the patient makes this treatment his own.

Gizella F., 49, begins her treatment with the strongest resistance. "People will think I am crazy if they hear this," . . . "I despise myself for having to do this" . . . "I am still convinced that if my husband had not lost his job, I would not have had this breakdown at all" . . . "How can I anyway come all this way several times a week, not having a car, and what shall I do with my children in all that time" . . ."I am afraid to talk about myself, in fact I hate to talk about myself, and what can that help" . . . and so on.

Although resistance and doubts continue to come up for a long time, the patient has already in reality three weeks after the start, taken her treatment in hand in probing into her past life, into decisions she has made, experiences she has gone through.

"To you I will admit that I was too vain to go back on my publicly-announced decision to marry this man" . . . "How can one be happy with a man with whom one can never be close and talk as one feels" . . . "I admit I begin to see how this works, I sleep a little better" . . . "I realize it would be my own fault if with this therapy I would not improve." . . .

Leonard M., 38, starts his twelfth interview by saying: "I want to try to get at some of those things which I am deliberately holding back. Although the antagonism may grow . . . I don't feel free with you, in fact I never felt I could lay myself fully open to any other individual . . . it may be that I feel somebody may take advantage of me. . . ."

Phase 3 is the period in which the *decisive emotional changes* and the patient's *reorientation in life* take place. These changes can be dramatic or more gradual. Sometimes the patient makes some of those *decisive discoveries* and the following *insights,* the experience of which K. Buhler called "aha-experience," after which many things at once fall into place.

The concept of "aha-experience" referred originally in K. Buhler's experiments to purely intellectual enlightenment during thought processes.[7] But it fits also the emotional insight in therapy so well that Fromm-Reichmann[8] attributed the concept to Freud, who very well could have used it.

"In this analysis, if something clicks," says *Eileen C.*, 29, "something wonderful happens; it is a sort of a numb sensation. I can't describe it."

If there are one or several of these dramatic insight experiences, they are often followed by new memories and they also result in the integration of previous treatment findings that were *then* not fully understood.

An interesting example is offered by the case of *Elliott N.*, 40, whom the court referred for psychotherapy after he had been committed for indecent exposure. Elliott, who had had several jail sentences previous to this episode, was a well-educated man, by profession an advertising writer, married, reasonably successful as long as his predicament did not throw him off the path, and extremely distressed over his uncontrollable impulses.

In the third hour after starting therapy, he volunteered the memory of a castration experience which was one of the great shocks of his earlier childhood. At six, when his mother too often found him masturbating, he was taken by her to a doctor with the threatening statement, "we will now have this cut off."

The doctor, not knowing about this threat, and obviously not psychologically yet quite up to date, put the boy without warning or explanation under ether and circumcised him. The patient remembers coming out of the ether convinced that his organ had been removed.

When asked how this whole experience affected him, he said, well, he was sore at his mother.

No interpretation was given, as it was not considered useful at this early stage.

In the following months, Elliott very successfully worked through his unhappy relationships with his family, especially his mother.

It was nearly a year later when Elliott suddenly saw in a strongly emotional aha-experience that in his exposures he probably tried and always had tried to give evidence of his masculinity being intact.

Eve N., 36, who for a year had been unable to overcome her rigid concern with what was proper and right behavior and her resentment over having yielded to premarital relationships with her husband, woke up one day feeling that this "whole righteousness" was complete nonsense and had ruined her life and her marriage.

This dramatic experience, of course, was not really sudden and mystical, but the result of an endless struggle to break the conformity pattern that

she had established in her early childhood-relationship with a rigid unfeeling mother. The process was one in which insight into what had happened during many years was supplemented by an unconscious inner reorganization which resulted in the sudden springing of the closed gate and her jubilant exclamation: "I feel . . ."

Not all treatments, however, culminate in dramatic insights. *Corrective emotional experiences* become effective in some patients in a gradual manner, with *unconscious interpretations* seeming to take place.

Milton K., 51, whose mother's excessive rejection and strictness made him look with apprehension and fear at all women because he did not trust them, showed an everyday increasing confidence and frankness with his female therapist. When the therapist asked him why he thought he now felt so much at ease with her, considering his general distrust of women, Milton insisted for a time that to him the therapist was not a woman, but a doctor. Only gradually could he recognize that his feeling toward women was changing.

The question as to which specific experiences in some cases do, and in others do not, result in decisive changes can obviously not yet be answered by anyone. It seems fairly certain, however, that it is not any one single experience, but that there usually are a great number, with sometimes a dramatic resultant and sometimes a gradual restructuring of feelings. Individual patients place different emphasis on different experiences in the process.

If *Edna S.* exclaims "Thanks to you I can now face all these people differently," she emphasizes the therapeutic relationship-factor much more than does *Eve N.*, who feels her own better understanding has made all the difference for her.

Some patients are not aware of how much they are changing until they are made to realize their improvement by comments of relatives or friends, or by a directive question of the therapist.

Different therapists may have different experiences in this direction because of variance in techniques or because of the types of personalities which favor particular techniques. In the author's material, patients who try to evaluate their experiences and their progress are in the majority.

Not infrequent, are cases in which the individual evaluates what difference certain insights did or did not make.

George B., a brilliant and outstanding musician of 36, whose deep depression affected his ability to play and who at the start had reacted with vio-

lent disgust to the whole idea of a psychological treatment, became eventually completely absorbed in the whole process.

In the eleventh interview he expressed the thought that some time rather early he had completely lost all confidence in himself and had lost zest for living, and that ever since he had been cold, empty and distant from everyone, although people did not know this and called him charming, gay and lucky.

In the next hours he brought considerable material in explanation of the peculiar trend of his past development.

Then he stated: "I have understood quite a lot about myself. It seemed to me I should now feel different. I am disappointed that I don't. I was at this party and felt just as distant and unfree as ever. . . ."

But a few hours later he reported: "Today I awoke with the feeling that life was wonderful and worth while living—for the first time in years and years. And why do I now suddenly *feel*? What has changed since last time?"

Nothing that he could see! But he realized that the cumulative effect of seeing so many things in a new light might have resulted in this free and happy feeling, which, of course, was again lost and had to be repeatedly reconquered.

Regardless of the variety in the modes of changing, *Criterion* 3 of therapy progress is that in this middle phase of the treatment there is *distinctive evidence* of the patient's *emotional reorientation* and of *personality reorganization.* The depth and extensiveness of these changes can vary considerably.

Characteristic of good progress in this third phase is also (*Criterion* 4) the *persistence, continuity* and *consistent development* with which the patient follows the lead of his discoveries, even though there were blocking and confusion at the start, and even though there are interruptions and setbacks during the process.

Some patients push forward with more energy than others, but no one stops in this period unless an impasse is reached that the patient does not feel equal to overcoming.

Vera M., 35, says repeatedly "today I want to talk again about my father . . ." . . . "I want to understand more about this . . . why does he still do this to me? . . . why do I like to be mean to him? . . ."

Eileen C., 29, usually opens the interview with a definite problem that she wants to talk about this time. For example: "I was going over this whole thing today, this fear of death, some of this is getting clearer to me . . ." . . . "I want to talk about this feeling of unreality, I never had it till all these things happened to me. . . ."

Marilyn C., 33, is energetically digging her way into her problems. "There is some basic weakness in me that I want to understand. Why do I let people always stop me?" . . . "I want to know more about this incomplete feeling that I have regarding any number of things. . . ."

Kay T., only 17, started rather reluctantly into her therapy and felt bewildered. But once she realized how much she had matured in a very short time, she took over completely and formulated her own problems. "I really like to know what makes me do these things, telling all these wild tales . . ." . . . "I try so hard to be a joiner, to be social, too hard, that's it exactly, I try too hard . . . it must be my insecurity, that's what it is, exactly, I *do* feel insecure all the time, but why do I? . . ."

Other patients are less active and less able to push their way forward. Their progress seems less continuous and less consistent as they may often feel thrown back and discouraged. Even their persistence may seem endangered, as they get tired and feel antagonistic toward the therapist and the whole idea of therapy.

Although partial success may in some cases be all that is attainable, progress and success are more satisfactory, the more persistence, continuity and consistency can be assured.

In this third phase the patient is now fully identified with his psychotherapy and has relinquished those defenses which blocked his *motivation toward health.*

This *motivation* has interested many research workers and has been emphasized particularly by Rogers as the decisive factor in the psychotherapeutic process.

While this is not the place to enter into a discussion of this basic striving toward growth, health, integration, independence, maturity, as described by Goldstein, Horney, Sullivan, Angyal, Mowrer and Kluckhohn, Rogers, and others, one characteristic of this motivation must be briefly brought into the fore because it is basic to the full understanding of the following fourth phase of the therapeutic process.

It is a fact that beyond the awareness of his own health, growth, freedom, independence, the human individual has a general knowledge of *how life ought to be lived,* not only in terms of those phases of life that he knows about by means of observations and learning, but also in terms of inner experience that no one may ever have told him about. For instance, a growing person not only knows that people usually get married when they grow up, but he also *anticipates* in some form the inner experience that this should

mean, and he *recognizes* later when married whether his *expectations* came true or not.

Stating this is not intended to imply that everybody has the right sort of expectations. In fact, many people obviously have great misapprehensions, and this is often an important feature of their illness.

The point to be emphasized is that there *are* anticipations based on some general knowledge of what life is about. This is *it*, this is what I had to have, says the healthy individual when he goes through an experience that he recognizes as *right* in the sense of what it ought to be.*

The third phase of treatment is the period in which not only wrong experiences of the past are rectified and wrong evaluations of the present have to be restructured, but also in which wrong expectations of the future must undergo changes. This outlook into the *future* is the main objective of Phase 4.

During the build-up of Phases 1 and 2, it usually becomes clear how far and how deeply the patient is able and willing to go in Phase 3. The criteria by which this can be judged must be left to another study. But in connection with the characterization of Phase 3, it must be said that the *optimal insight to be achieved* in a case belongs in this central phase. Once the patient has given up digging and searching for facts that increase his self-understanding, and has gone on to other problems, it is difficult to get him back unless the process is, in a way, reopened. "I know all that, but what do I do now" is sometimes the attitude of patients who think they have reached their best potential insight. The success of a treatment and the value of the whole process seem to depend very much on the therapist's ability *to recognize, to bring about and to help to utilize an individual's optimal insight.* The problems involved in the process of gaining new directives from this restructured outlook on life lead to the fourth phase.

Phase 4 brings the reaping of whatever harvest has grown. *Criterion* 5 of successful therapy is that the patient now shows his ability to *realize and integrate* what he has gained.

Some patients are able to summarize, all during the process, what they have gained through understanding, while others have

*See the discussion of "anticipation" in the author's aforementioned article on maturation and motivation, and in "The Human Course of Life," in preparation.

to be helped with specific or summarizing interpretations. It is decisive, however, that integrative actualization of the insight obtained should take place toward the end.

Leonard M., 38, from early in the process often made self-evaluations. "I can see that while I am intellectually eager to get better," he said two months after beginning, "there are obviously things I am scared to find out about myself." Three months after beginning he said, "Not since coming here have I had any real emotional upset with my mother." Five months after beginning: "I have realized a few things, I think. That it is possible after all to change one's outlook on things. I believe now it is possible for a person to live a full life. And not necessarily in avoiding pain at all costs. I begin to enjoy life. Am really awfully pleased at the progress I made in this short time. Feel lots better than I expected I would, moods of depression very much rarer—little things used to bother me for days, am amazed how quickly I get over some of these hurts" . . . "First time in my life, I see mother fairly objectively."

At six months: "Things begin to fall into place, realize how I was tied up in knots . . . begin to see clearly the poverty of my life up to now. Missed so many experiences. It scares me how much I have to do to catch up." Toward the end, after seven months: "I am going far beyond what I ever thought myself capable of before. Up to a few months before, I resigned myself to just getting by in life, did not consider myself any use for any fairly desirable woman . . . now discover myself able to hold any girl's interest and to chat with my colleagues and be at ease."

When a considerable amount of dynamically decisive experiences have been restructured and important areas of life have been cleared, when the patient has become more accepting of himself, of his past and of other people *he turns from past and present to the future. Criterion* 6 of the successful process-organization is that the patient has become enabled to *direct himself toward an adequate fulfillment.**

As the patient was emotionally blocked and in this way prevented from seeking an adequate fulfillment previously, he will now be able to direct himself. *Leonard M.* was an example of a case freed by therapy to follow goals he always *knew* to be the right ones.

But to the degree to which a patient has been handicapped by improper education, by absence of ego-ideals with which to identify, by constitutional defects or consequences of severe illnesses

*"Fulfillment" was defined in the author's "Human Course of Life as a Psychological Problem" as the experience of accomplishment which, at the end of a life, lets the individual feel at peace with himself, his environment and with the Universe or his God.

or by lack of resourcefulness, the patient, even after gaining considerable insight, may not be able to give himself adequate directives. The assumption that *restoration to emotional health* and *ability to set up proper goals* are identical, means taking things for granted that just are not so, even within the range of normal intelligence. Resourcefulness and opportunities are factors that cannot always be presupposed. It seems to this author an incomplete treatment-process to leave the patient to himself when he is at the threshold of a new life and handicapped in finding his place in it. The therapist's personality, experience, wisdom and own outlook on life here become factors of theoretically underestimated importance.

Beyond handicaps of the patient's directivity, another question is often asked during this period, or asked before but only now discussable, the question, "What are we living for?" . . . "What can we believe in?" This question has a serious impact in cases in which the patient was actually tested beyond endurance by realities such as actual extreme unfairness, loss of freedom, tortures, or if he is strongly aware of these factors in the world as it is.

Undoubtedly these statements will cause controversy, as it is one of the basic principles of the psychoanalytic method not to direct or guide the patient, and still stronger emphasis is given to this idea in Rogers' "non-directive" therapy.

The *dogma of non-interference* in these theories is of course relative. As soon as two human beings come together, there is interaction. The direction which the patient obtains from the point of departure that the non-directive therapist takes in his repetitious questioning, or from the interpretations that the psychoanalytically-oriented therapist provides, is, in essence, as much direction as any other information given. The decisive point in which older and more recent methods in psychotherapy and counseling differ is that the patient must retain freedom of choice and of movement. In this sense, advice and suggestion appear undesirable to present-day psychiatric thinking. But to eliminate all information and discussion—about possible ways of living and of interpreting life—from the end-phases of the therapeutic procedure is to force psychotherapy into an extremely one-sided pattern. It means eliminating from this re-educational procedure all instruction that might be helpful, just for the sake of the principle that the patient might find his own way. This recalls similar extremist movements in

education when students were expected to rediscover all principles of science for themselves. Rather than avoid all informative discussions, the principle ought to be to avoid giving advice when informing, and to avoid one-sidedness of information where views are still in flux.

Although this is not the place to give this problem the consideration and space it deserves, a few examples may indicate the type of cases in which directive discussions seem called for as compared with those where the patient finds his own way.

George B., 36, discovered during his treatment that one of the basic errors of his life had been the improper standards by which he was guided and which made him feel forever inadequate and that nothing he did was worth while doing. When emotionally free enough to reorient himself, he gave himself for his work, as well as for his personal life, completely new, much more modest and realistic directives, which enabled him to enjoy for the first time his accomplishments as a musician, and his family as the people he wanted to devote himself to and to live for.

Marilyn C., 33, discovered early in her therapy that "somewhere in her life she had made a wrong turn—somewhere in the machine it is like a burr, it is caught, that somehow she was not given to life as she ought to be." She realized furthermore without help that because of her dependency on and conformity with the principles of her mother, she had let herself be deprived of the relationships that would have given her the greatest happiness. To the degree to which she freed herself from her mother, she felt able to recognize and to follow her own basic needs which she had disregarded too much in many respects.

Different from the last two are the following cases:

Edna S., a 53-year-old secretary, felt after overcoming the emotional impact of her mother's, her family's and her divorced husband's rejections, that her life and work held little interest and that she did not know where to turn to get any feeling of accomplishment and fulfillment. A number of discussions on the worthwhileness of contributing to some constructive doing beyond her own small existence, and discussions on possible causes that would interest her, led to the decision to devote her free time to campaign work for cancer and polio research funds, since she had lost her favorite brother through an early death from an undiscovered cancer. She felt this was work she could believe in as worth while.

Mortimer G., 26, suffered in his personal as well as his work relationships from the consequences of an unhappy childhood without affection from either parent. He interpreted this not only as a misfortune but as an injustice perpetrated by life, and he was quick to discover injustice wherever he looked. Unfortunately some superiors in the firm in which this brilliant

engineer was employed, laid themselves wide open to possible criticism in the direction of unfair decisions and Mortimer felt convinced that this was the pattern of life in general.

Since injustice undoubtedly is a reality factor and it could be a subject of controversy whether there is more injustice or more justice in this world, it seems hardly sound to expect a person who has suffered to resign himself to an objectionable status quo. Rather it seems more appropriate to discover, with the patient, ways and means in which he as an individual, might help to contribute to fairer doings and find satisfaction and peace in helping to create what is missing. This can only be done in giving possible new directions to this patient's thinking.

Phase 5 is successfully reached when (*Criterion* 7) patient and therapist recognize that the process of therapy has come to a *potential close.* This is the case when the patient feels that he has *integrated the past, present and future of his life into a whole,* and that he can go on alone from here and continue to grow.

"I think I have graduated now" says *Eve N.*, now 37, at the close of her treatment. "Now I know I understand and I feel as I should . . . this man of mine is just part of me and for the first time in 15 years he said last night things were right . . . I have no more headaches, I have no more pressures, I have changed so much it is incredible . . . I never knew what love was . . . I am completely untied from my mother. I understand now why I had to conform so excessively with her principles . . . I shudder now at the person I have been. How cruel I have been . . . I never felt so right in my life. I feel so lucky . . . I look back at the time where I had no conception of what all this was about . . . this feeling and this certainty are growing and growing. I know now this will no more change, I am sure of myself."

Turning from the successful treatment's process-organization to the *criteria of the unsuccessful and the disrupted treatments,* it seems the *main criterion of the unsuccessful attempt at therapy* is that in these cases the patient is *unable even to start the process of the therapeutic-relationship and catharsis.*

There are of course a number of different reasons for conditions which block even the beginning of this process, the most decisive being people's fear to face themselves as they really are and to let someone else know about their weaknesses. This self-defense is particularly evident in the many patients who insist that *all they need is advice* and who are unable to accept the whole idea of therapy.

In this author's material, this situation obtains particularly often

with a number of older persons who take offense at the idea of possible personality changes, or even changes of point of view, and who feel that it is beyond their dignity to have anything else suggested but techniques of handling situations.

In treatments with *premature termination* it can be found that the process previous to the disruption usually does not fulfill most of the criteria mentioned before. Frequent failures of the defective process are:

Negative Criteria

1. *Poor therapeutic relationship,* interrupted by periods of estrangement, remoteness, doubts, suspicion, hostility, even after these factors have been interpreted for the patient and he has been urged to explore these attitudes.

Roger C., 35, says repeatedly during several months: "I guess I can't get close to anyone except my wife. I just don't care for anyone."

Douglas R., 28, declares repeatedly, "there may be a fair chance to be helped by therapy, but then one of my friends and one of my cousins are in psychoanalysis and I think they are not in good shape at all." Or later: "I wonder whether I will ever stop doubting you. I doubt everyone, just can't help it, I guess."

2. *Unconscious or even conscious determination not to be influenced.*

Roger C., 35, declares from the start and without changing this attitude: "You cannot change me, I know it. Nobody can change me." He discredits any sign of progress: "I said all this before, it is not really different from what I said before"—"I feel always the same, there is no change."

David B., 28, says, "The world is a rotten place, I tell you, and you can't change my opinion about it."

Cynthia A., 48: "If you could convince me that this is the right thing for me, but I don't think I will ever be able to believe in psychology. I must go back to metaphysics. If I only have the right faith, my pains must disappear then . . ."

3. The patient will *not take over* sufficiently, but puts it up to the therapist to get him well. "Now if you just could tell me" . . . "I really don't know where to go from here" . . . "I can't tell you anything more, you know everything already" are the phrases repeated in such cases.

4. The patient seems *unable to accept interpretations* or to *learn to interpret* by himself; instead he continues to *rationalize, intellectualize, ask for theoretical explanations,* or to *moralize* and

to talk about the *things he ought to do or the things he is now sure to do right.*

Some patients cannot get beyond the state of perverse satisfaction of denouncing themselves and of moralizing about themselves.

Eddie S., 24, blames himself for having a "big mouth," acting like a "phony, a braggart," having "never done anything nice for anybody," having "no value at all." But he cannot get beyond reporting faithfully all the mean things he does and moralizing about the things he should do instead, and in spite of his dogged determination to be treated, he is unable to co-operate with the idea and procedure of therapy.

5. There is *no development, no corrective emotional experience,* but a *persistent repetition* of the same complaints *beyond their cathartic function.*

It is very instructive to compare the different structure of those cases in which interminably repeated complaints are finally successfully consummated with those in which no benefit is obtained.

Neither *Maude G.*, 48, nor *Milton K.*, 51, had overcome the traumata inflicted on them by mothers who used to beat them unmercifully and showed them every possible sign of rejection in comparison with their treatment of their siblings.

For several months, these two patients went on repeating their complaints. Milton felt at the end of this period that he had gotten over what his mother did to him, that his tension and other psychosomatic symptoms had left him, and that he could begin to look at life in a new way.

Maude, while admitting after several months that she did not feel quite so bitter any more, still could not see that this got her any further in her problems of life which were her inability to enjoy anything, to interest herself in anything, or to make friends.

The main difference between Maude and Milton lay in the fact that Milton had retained his own personality, his ability to enjoy and to do things, in spite of the impact of his mother's destructive influence. Maude had not been able to hold her own at all and was impoverished when the hostility was lessened. Thus Milton had many interests and correlated contacts to fall back on, while Maude had nothing at all when her hatred and anxieties were beginning to abate.

Maude was unable and unwilling to make a "corrective emotional experience," but held on to her hatred and bitterness. This seems the main difference between those innumerable repetitions which

gradually lead to an overcoming of the emotional injuries of the past, and those which accomplish no changes at all. Maude does not, while Milton does, respond to the therapist's understanding and kindness. There is consequently no change of outlook for Maude, while Milton's feelings about the world, about people, and especially about women, become continuously more adequate.

6. *Insight may be inadequate or inadequately utilized.* Some of the initially-discussed cases that had reached an impasse belong in this group.

Martha S., 42, felt, after a childhood in extreme poverty and a life with many illnesses and personal disappointments, that "life" had passed her by and "was not worth it," that "nothing worked out that she ever tried," and, "what was the use?"

Although she recognized gradually her own part in much of her misfortune and that much of it she caused for herself, she decided after five months of therapy that it is "too late" and "nothing any more can make a difference." Although she liked to talk and to complain and wished to continue talking, she refused to apply any of the insight achieved and to try anew to find something worth while in life.

7. *Inability to build toward the future,* to direct the self to constructive contributions.

Roger C., 35, a very capable chemist, had no use for what he was doing, saw no future that interested him, felt his wife should leave him and not bother with him, and was convinced that only habit made him go on.

At the end it must be said that any one of these negative signs can occur in a treatment that ultimately turns out to be successful. That is to say, only when many or all of these negative criteria are present does the treatment probably fail. No therapy is of course without periods of resistance, of negative transference, of defenses against interpretations, and other negative signs. But it seems safe to say that if a majority of negative, and only a minority of, or no, positive criteria are present, a treatment does not succeed.

Even then, it must be emphasized, the disrupted treatment can be partially successful. A patient may, in spite of his temporary resistance against the process, accomplish a certain amount of insight, which later proves to have helped him partially or considerably in certain respects or which makes him return at some later time for further treatment.

Ending this presentation with a figure, it can be reported that in the sample of 125 cases, 32 of which disrupted their treatments in advanced phases, 14 either returned for continuations or gave evidence of unexpectedly-good later adjustments.

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A COMPARISON OF FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DURING 1919-1921 AND 1949-1951

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During the three years ended June 30, 1921 there were 20,303 first admissions to the New York civil state hospitals, or an annual average of 6,768. This represented an average annual rate of 65.2 per 100,000 general population. Since 1920 there have been a number of important changes in the population of New York State. In the first place, there was a great growth in numbers, from 10,385,227 in 1920, to 14,830,192 in 1950.

Some of the relative changes within these totals might have been expected to reduce the rate of first admissions. For example, the rate of first admissions to the state hospitals is lower for females than for males. Between 1920 and 1950, the ratio of males to females was reduced from 99.8 males to 100 females in 1920 to 95.4 males to 100 females in 1950. Because of restriction of immigration since 1920, the native white population increased from 71.1 per cent of the total in 1920 to 76.7 in 1950. Such a change would be associated with a reduction in the general rate of first admissions. A further favorable change was with respect to the urban-rural distribution. Instead of continuing the long trend toward greater urbanization, the percentage of urban population decreased from 82.7 in 1920 to 80.2 in 1950, as a result of shifts in recent years to suburban areas. However, the most important change in population, the age distribution, has had an unfavorable influence on the rate of first admissions. In 1920, the median age of the general population was 27.6 years. In 1950, it was 33.7 years. In 1920, persons aged 60 or over numbered 807,009, or 7.8 per cent of the total population. By 1950, they had increased to 1,943,142, or 13.1 per cent. These shifts are reflected in corresponding changes in the characteristics of patients admitted to the state mental hospitals.

This analysis may be begun with a consideration of changes in the annual rate of first admissions. The male population of New York State grew from 5,187,350 in 1920 to 7,239,944 in 1950, an increase of 2,052,594, or 39.6 per cent. The average number of male first admissions to the New York civil state hospitals grew from 3,519 a year in 1919-1921 to 7,823 a year in 1949-1951, or by 122.3

Table 1. First Admissions to the New York Civil State Hospitals, 1919-1921 and 1949-1951

	1919-1921			1949-1951		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Males	10,556	52.0	67.8	23,469	50.0	108.1
Females	9,747	48.0	62.5	23,433	50.0	102.9
Total	20,303	100.0	65.2	46,902	100.0	105.4

per cent. Male first admissions therefore grew three times as rapidly as the general male population.

Among females, the general population grew by 2,392,371, from 5,197,877 in 1920 to 7,590,248 in 1950, or by 46.0 per cent. The average number of female first admissions increased from 3,249 annually in 1919-1921 to 7,811 annually in 1949-1951, an increase of 140 per cent. Thus, not only did the female first admissions grow more rapidly than the general female population of New York State, but they also increased more rapidly than male first admissions. In 1919-1921, males represented 52.0 per cent of the total first admissions, females 48.0 per cent. In 1949-51, the sexes had 50 per cent each. The average annual rate of first admissions per 100,000 corresponding population grew among males from 67.8 in 1919-1921 to 108.1 in 1949-1951. Among females, the corresponding rates were 62.5 and 102.9, respectively. For the sexes combined, the 1919-1921 and 1949-1951 rates were 65.2 and 105.4. In comparing the sexes, it must be noted that the number of male first admissions to the state hospitals in 1949-1951 is lower than might have been expected, because many veterans of both World Wars are now being admitted directly to hospitals administered by the United States Veterans Administration.

Next to increase in absolute numbers, the change in the relative distribution of the first admissions according to age is probably the most important difference between the 1919-1921 and 1949-1951 periods. The median age of the first admissions increased from 40.5 years to 52.1 years. The growth of the number of the aged is responsible for the increase in the median age of all first admissions. Those aged 60 or over included only 19.1 per cent of the total first admissions in 1919-1921, but they included 40.0 per cent in 1949-1951. Among males, these percentages changed from 18.1

Table 2. First Admissions to the New York Civil State Hospitals, 1919-1921 and 1949-1951, Classified According to Age

Age (years)	1919-1921 Number			1919-1921 Per cent			1949-1951 Number			1949-1951 Per cent		
	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 15	41	31	72	0.4	0.3	0.4	439	250	689	1.9	1.1	1.4
15-19	543	420	963	5.1	4.3	4.7	950	921	1,871	4.0	3.9	4.0
20-24	1,018	794	1,812	9.6	8.1	8.9	1,843	1,344	3,187	7.9	5.7	6.8
25-29	1,225	1,161	2,386	11.6	11.9	11.8	1,884	1,728	3,612	8.0	7.4	7.7
30-34	1,209	1,127	2,336	11.5	11.6	11.5	1,574	1,740	3,314	6.7	7.4	7.1
35-39	1,317	1,071	2,388	12.5	11.0	11.8	1,577	1,790	3,367	6.7	7.6	7.2
40-44	1,057	946	2,003	10.0	9.7	9.9	1,577	1,581	3,158	6.7	6.7	6.7
45-49	889	882	1,771	8.4	9.0	8.7	1,472	1,526	2,998	6.3	6.5	6.4
50-54	736	777	1,513	7.0	8.0	7.4	1,547	1,442	2,989	6.6	6.2	6.4
55-59	615	575	1,190	5.8	5.9	5.9	1,543	1,392	2,935	6.6	6.0	6.3
60-64	571	514	1,085	5.4	5.3	5.3	1,742	1,413	3,155	7.4	6.0	6.7
65-69	508	399	907	4.8	4.1	4.4	1,799	1,551	3,350	7.7	6.6	7.1
70 or over	827	1,050	1,877	7.8	10.8	9.2	5,522	6,755	12,277	23.5	28.8	26.2
Total	10,556	9,747	20,303	100.0	100.0	100.0	23,469	23,433	46,902	100.0	100.0	100.0

to 38.8. The corresponding percentages among females were 20.1 and 41.4. If one draws the line higher, so as to include only those aged 65 or over, the corresponding percentages in 1919-1921 and 1949-1951 were 13.7 and 33.3, for the total first admissions.

Though it is on a much smaller scale, attention should also be directed to the growth in first admissions under 15 years old. In 1919-1921 they numbered only 72, or 0.4 per cent of the total. In 1949-1951 they included 689, or 1.4 per cent of the total. The number of such first admissions increased by over 800 per cent during the three decades, whereas the general population of the same age increased by only 11.6 per cent. The increased number of such first admissions is associated in large part with the admission of those classified as "behavior disorder," a category which did not exist in the standard classification of mental disorders in 1919-1921. However, there has been an equally large relative increase in the admission of cases diagnosed as dementia præcox.

Table 3 shows the average annual number of first admissions per 100,000 general population of corresponding age and sex. In general, the rates rose from minima at the younger age levels to maxima among those of advanced age. In practically every age group, the rate of first admissions was higher in 1949-1951 than in 1919-1921. Some exceptions to this trend appear among males at the ages of 35 to 44, and it is possible that this results from the admission of war veterans to federal rather than to state mental hospitals. However, this factor does not explain the reduction in rates among females aged 40 to 54. As it is not likely that the rate of mental disease has actually decreased at these ages, it is possible that there has been to some extent a substitution of private for public hospitals. Data along these lines are lacking for 1920, and the hypothesis cannot be tested. Table 3 bears out the significance of the changes in the age distribution. The highest rate of increase was among those aged less than 15 years, among whom the rate increased by 763 per cent. There was a slowing of the rate of increase between 15 and 44. After 45, the rates began to rise more rapidly for the 1949-1951 period, the greatest rates of increase having occurred after 60 years of age.

The general population of New York State differed significantly in 1950 from that of 1920, in age distribution and sex ratio. Each has an important relation to the rate of first admissions. Therefore, the rates have been recomputed, so as to place the first admis-

Table 3. Average Annual Rates of First Admissions to the New York Civil State Hospitals, 1919-1921 and 1949-1951

Age (years)	1919-1921 (a)			1949-1951 (b)			Ratio (b/a)		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 15 ..	0.9	0.7	0.8	8.6	5.1	6.9	9.56	7.29	8.63
15-19	45.3	33.4	39.3	71.4	66.6	69.0	1.58	1.99	1.76
20-24	78.2	53.9	65.3	120.2	78.1	97.9	1.54	1.45	1.50
25-29	85.6	78.3	81.9	109.4	91.0	99.8	1.28	1.16	1.22
30-34	89.0	85.6	87.3	94.4	93.9	94.2	1.06	1.10	1.08
35-39	101.2	88.0	94.8	93.2	95.3	94.3	0.92	1.08	0.99
40-44	98.9	91.9	95.4	95.2	90.9	93.0	0.96	0.99	0.97
45-49	92.5	99.0	95.6	95.8	97.5	96.7	1.04	0.98	1.01
50-54	90.8	99.4	95.0	105.7	97.3	101.4	1.16	0.98	1.07
55-59	104.9	99.5	102.2	124.0	112.2	118.1	1.18	1.13	1.16
60-64	121.7	108.7	115.2	169.9	137.4	153.6	1.40	1.26	1.33
65-69	166.4	124.0	144.6	238.3	185.7	210.7	1.43	1.50	1.46
70 or over	215.6	224.1	220.3	572.8	553.2	561.9	2.66	2.47	2.55
Total ..	67.8	62.5	65.2	108.1	102.9	105.4	1.59	1.65	1.62

sions of 1919-1921 and 1949-1951 on comparable bases. For this purpose, standardized rates of first admissions were computed, and are shown in Table 4. The population used as the standard

Table 4. Average Annual Standardized* Rates of First Admissions to the New York Civil State Hospitals, Fiscal Years 1919-1921 and 1949-1951

	1919-1921 (a)	1949-1951 (b)	Ratio (b/a)
Males	101.0±1.11	142.4±1.09	1.41 to 1
Females	93.3±1.06	124.8±0.98	1.34 to 1
Total	97.6±0.77	135.5±0.73	1.39 to 1

*Population of New York State aged 15 years or over on April 1, 1950, in intervals of five years, used as standard.

was that of New York State, aged 15 years or over, as shown by the federal census of April 1, 1950. The standard population was divided, by sex, into intervals of five years. On this basis, the average rate of first admissions to the New York civil state hospitals rose from 97.6 per 100,000 population in 1919-1921 to 135.5 in 1949-1951, an increase of 39 per cent. The rates rose among males from 101.0 to 142.4, or an increase of 41 per cent. The corresponding rates among females were 93.3 and 124.8, respectively, an increase of 34 per cent.

Table 5. First Admissions to the New York Civil State Hospitals, 1919-1921 and 1949-1951, Classified According to Mental Disorders

Mental disorders	1919-1921 Number			1919-1921 Per cent			1949-1951 Number			1949-1951 Per cent		
	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	2,059	468	2,527	19.5	4.8	12.4	804	341	1,145	3.4	1.4	2.4
With other syphilis of cen. nerv. system	82	47	129	0.8	0.5	0.6	96	67	163	0.4	0.3	0.3
With epidemic encephalitis	15	14	29	0.1	0.1	0.1	57	43	100	0.2	0.2	0.2
With other infectious diseases	98	167	265	0.9	1.7	1.3	78	41	119	0.3	0.2	0.3
Alcoholic	461	123	584	4.4	1.3	2.9	2,350	728	3,078	10.0	3.1	6.6
Due to drugs or other exog. poisons	27	38	65	0.3	0.4	0.3	52	102	154	0.2	0.4	0.3
Traumatic	52	4	56	0.5	*	0.3	276	50	326	1.2	0.2	0.7
With cerebral arteriosclerosis	862	593	1,455	8.2	6.1	7.2	5,247	4,686	9,933	22.4	20.0	21.2
With other disturbances of circulation	47	63	110	0.4	0.6	0.5	118	140	258	0.5	0.6	0.6
With convulsive disorders	295	230	525	2.8	2.4	2.6	365	272	637	1.6	1.2	1.4
Senile	799	1,183	1,982	7.6	12.1	9.8	2,760	4,435	7,195	11.8	18.9	15.3
Involutional	203	563	766	1.9	5.8	3.8	1,063	2,127	3,190	4.5	9.1	6.8
Due to other metabolic, etc., diseases	79	192	271	0.7	2.0	1.3	90	146	236	0.4	0.6	0.5
Due to new growth	21	13	34	0.2	0.1	0.2	126	101	227	0.5	0.4	0.5
With organic changes of nervous sys.	51	46	97	0.5	0.4	0.4	192	145	337	0.8	0.6	0.7
Manic-depressive	993	1,882	2,875	9.4	19.3	14.2	398	710	1,108	1.7	3.0	2.4
Dementia præcox	3,101	2,744	5,845	29.4	28.2	28.8	6,729	7,091	13,820	28.7	30.3	29.4
Paranoia and paranoid conditions	155	164	319	1.4	1.7	1.6	113	91	204	0.4	0.4	0.4
With psychopathic personality	267	224	491	2.5	2.3	2.4	382	306	688	1.6	1.3	1.4
With mental deficiency	264	276	540	2.5	2.8	2.7	400	479	879	1.7	2.0	1.9
Psychoneuroses	135	225	360	1.3	2.3	1.8	798	939	1,737	3.4	4.0	3.7
Undiagnosed	389	421	810	3.7	4.3	4.0	159	107	266	0.7	0.4	0.6
Without psychosis	101	67	168	1.0	0.7	0.8	555	131	686	2.4	0.6	1.4
Primary behavior disorders	..	..	..	..	..	..	261	155	416	1.1	0.7	0.9
Total	10,556	9,747	20,303	100.0	100.0	100.0	23,469	23,433	46,902	100.0	100.0	100.0

*Less than 0.05.

First admissions during the two trienniums are classified according to mental disorders in Table 5. It is evident that the distributions have changed in a very significant way during the 30 years. It may be noted first that there were 2,527 first admissions with general paresis during 1919-1921, or 12.4 per cent of the total first admissions. Despite an increase of 40 per cent in the general population during the next three decades, the number of first admissions with general paresis during 1949-1951 numbered only 1,145, or 2.4 per cent of the total first admissions. Another sizable decrease occurred among first admissions with manic-depressive psychoses. These numbered 2,875 during 1919-1921, or 14.2 per cent of the total first admissions, compared with 1,108, or 2.4 per cent, during 1949-1951. The consistency of the downward trend year by year makes it probable that the decrease cannot be explained by mere reference to fashions in diagnosis. Other groups of mental disorders have increased, however. The alcoholic psychoses included 584 first admissions in 1919-1921, or 2.9 per cent of the total, compared with 3,078 during 1949-1951, or 6.6 per cent.

The most remarkable increase was in psychoses with cerebral arteriosclerosis. First admissions with such psychoses grew from 1,455 during 1919-1921 to 9,933 during 1949-1951. During these periods they represented 7.2 and 21.2 per cent, respectively, of the total first admissions. First admissions with senile psychoses numbered 1,982 in 1919-1921, or 9.8 per cent of the total, but they represented 7,195, or 15.3 per cent, in 1949-1951. First admissions with involutional psychoses grew from 766 to 3,190, or from 3.8 to 6.8 per cent. Dementia præcox accounted for 5,845 first admissions in 1919-1921, compared with 13,820 in 1949-1951. Even with the more rapid growth of some other groups of mental disorders, dementia præcox included 29.4 per cent of the total first admissions during the latter period, compared with 28.8 during 1919-1921. On a smaller scale, an interesting comparison can be seen with respect to primary behavior disorders. These included 416 during 1949-1951. There were so few such cases in 1919-1921 that the standard classification did not include this group at that time.

Summary

The average annual number of male first admissions to the New York civil state hospitals increased from 3,519 during 1919-1921 to 7,823 during 1949-1951. The increase was greater than the corre-

sponding relative growth of the general male population of New York State, so that the average annual rate of first admissions per 100,000 male population increased from 67.8 to 108.1. Female first admissions showed a corresponding growth, both in numbers and in rate per 100,000 general female population. Within the period of three decades, the average annual number of female first admissions increased from 3,249 to 7,811, and the average annual rate increased from 62.5 to 102.9.

The most important change in the characteristics of the first admissions was with respect to age. The median age of first admissions increased from 40.5 years in 1919-1921 to 52.1 in 1949-1951. Those aged 60 or over included only 19.1 per cent of the total first admissions during the former period, but 40.0 per cent during the latter period. Though on a much smaller scale, there was a significant growth in the number of first admissions under 15 years of age.

Accompanying these changes with respect to age, there were significant changes with respect to the distribution of the mental disorders during the two periods. First admissions with psychoses with cerebral arteriosclerosis increased from 1,455 during 1919-1921 to 9,933 during 1949-1951. They represented 7.2 and 21.2 per cent, respectively, of the total first admissions during these periods. First admissions with senile psychoses increased from 1,982 in 1919-1921, or 9.8 per cent of the total, to 7,195 in 1949-1951, or 15.3 per cent. There was also a marked increase with respect to first admissions with involutional psychoses. Dementia præcox represented the largest single group of first admissions, growing from 5,845 in 1919-1921, or 28.8 per cent of the total first admissions, to 13,820, or 29.4 per cent in 1949-1951. On the other hand, there has been a noteworthy decrease of first admissions with general paresis, and a marked decrease with respect to first admissions with manic-depressive psychoses.

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EDITORIAL COMMENT

MAN AND HIS MORALS

The time may have come, or maybe it is more simply still here, to jot down a few more random thoughts in what the editors sometimes think of as this QUARTERLY's "notes on man and morals series." Even though it is today a widely-accepted postulate that man is more often weak than wicked, medicine still has to fend off the assaults of assorted moralists who appear to believe in the innate depravity of human nature and see, in medical conclusions, only apologetics for reprehensible behavior. One may point out to the contrary, however, that it is sound psychiatric thought that man is a more admirable specimen than the extremist Puritan sees in him, that his "moral" stature has been growing since time immemorial, and that his present accomplishments as a tolerable—if not desirable—species are something in which to take pride, not shame.

These judgments are all subjective, of course; they are the sort of thing described by adjectives which, at one time or another, are all things to all men; and they are best maintained by broad assertions with the loosest of documentation—not by statistical proof. Man proving his own nobility by statistics would be something to arouse ire and laughter on Olympus. But man can still dare—and hope not to call down thunderbolts or sneers—to take a panoramic view, make a wide and general survey of himself, his past, his present, his accomplishments and failures, his hopes, ambitions and fears, and to take courage in concluding therefrom that if he is not so good as he would like to be, he is somewhat better than he used to be, and far, far better than he might be.

That is a firm and, one hopes, soundly based conclusion in which one might guess the majority of psychiatrists and their fellows in related social sciences might join; and it is a pleasure, if not a duty now and then, to make note when such others give sign of concurring in it. What brings this idea to mind is a three-day conference on moral standards, attended by some hundred representatives of education, business and the professions, which representatives concluded after considerable discussion that American

group and individual moral behavior was "far better" than most of them had been in the habit of thinking it was. Signing this finding for the conference were: Professor Emeritus of Education Lyman Bryson of Teachers College, Columbia University; Chancellor Louis Finkelstein of the Jewish Theological Seminary of America; and Professor of Philosophy and Greek Richard P. McKeon of the University of Chicago.

These conferees are, certainly, not responsible for any theories, ideas, or supporting evidence for their stand, which may be discussed here; but it is both significant and gratifying to note that representatives of pedagogy, theology and philosophy (to cite the three disciplines of these signers only) can subscribe to conclusions with which psychiatry, on much detailed clinical, and even more broad general, evidence can agree.

Just as there have been vast meteorological changes from geologic era to era, so the armchair philosopher-historian, or even the earnest student of the encyclopedia, can see what appear to have been extraordinary changes from society to society and age to age in the moral climate of man. There have been places and periods of harshness and storm; of calm and warmth; of dry, desert heat; of chill from the northern steppes; of avalanche and turmoil from the mountains; of cool invigoration from the wide sea and the splendid reach of the great plains. Man's temper can be described in terms of rain and sun, almost as truly as his environment. Of course his moral temper and his environment have by no means coincided.

One may see, for instance, the moral climate of Puritan New England of Colonial days as chill, damp, cheerless, gray, dispiriting. If this is fancy, it is one that is widely shared, for it is a description familiar for several generations of American literature. But the moral climate, not the environment, changed; man's internal warmth grew; his sun shone more brightly; his seasons mellowed; and there came a period called most appropriately by a famous chronicler "the flowering of New England." The land can be the same, but men's hearts can change.

The moral standards of today should bear comparison with those of which we know, of any times before. How long man has existed we do not know; whatever his origin and manner of creation, his history is comparatively short. Astronomy and geology recently reached agreement on an age of something like four billion years

for the earth (and the universe). The longest estimates of competent authority put the existence of any creature that might be called human back only half a million years or so. Recorded history goes back at the most about six thousand years—both these spans are of microscopic triviality compared with astronomic or geologic time.

But man, in his trivial period of existence, has become a cleaner, pleasanter, more reliable, more considerate creature than he used to be. In most parts of the world, one man can meet another now without each wondering whether the stranger is thinking of making a meal of him, and without estimating the possibilities of making a meal of the stranger. Father and sons can live in social contact without homicide over father's women. In our society, women can dispose of themselves and their possessions. The social obligation is recognized to see that no one dies of hunger or exposure; in our own country, the individual has specified and recognized rights—in the enjoyment of which he is protected by society—to do such things as choose his own work, his own residence, his own religion, his own associates, to read what he pleases, go where he pleases, see what he pleases, and, above all, think what he pleases. Such rights vary in kind and in their limits. But they exist to a greater degree and over more of the surface of the earth than ever before.

Whether the existence of such things is morality in itself, or whether they are simply evidence that morality exists, is a matter for philosophical or theological debate. They are at any rate matters by which one can judge a state of morals; and they are matters to which human beings have strong subjective reactions. People are not neutral about such things as patricide or cannibalism; they are not—as a matter of common and general observation—indifferent to whether men and women starve or freeze to death; and they, in general, feel strongly over whether men and women should enjoy the freedoms we enjoy or are better off in authoritarian societies.

As customs change, ideas of morality change. It is an anthropologist's rather grisly joke that (like the people who were said to live by taking in each other's washings) some long-vanished specimens of primitive men lived by eating each other's brains. If Sinanthropus Pekinensis (against whom this particular libel is leveled) did, indeed, dine in this fashion, he doubtless saw nothing

immoral about it. Either Sinanthropus came first and morality later; or his revolting habits were moral according to his standards, a suggestion most social scientists would probably consider the more likely, for wherever living man has been found and wherever his departed ancestors have left decipherable records, there seem to have been recognizable customs and standards of behavior; and customs and standards of behavior among human beings seem always to be based on something which must be regarded as some variety of morals.

As time went on, as Sinanthropus reformed or disappeared, there appears to have developed slowly what anybody today would regard as a higher level of human morals. However tyrannous and troublesome his sons found him, it became considered immoral to kill and eat the old man. By degrees, it seems to have become judged to be immoral to eat the neighbors, to eat fellow-tribesmen, and finally to eat anybody. By "immoral," is meant, for purposes of this discussion, conduct which, judged by the accepted principles of tribe or society, would be held to be wrong. By "morality," is meant the principles generally accepted at any time or place to govern right conduct, by "immorality," the disregard of moral principle and the practice of conduct held to be wrong. Also, one cannot escape here the frame of reference which comes from our own society's moral standards. Inescapably we judge the worth of alien moral systems and man's general progress or decay in morals by comparison with the standards we consider our own. And we justify those standards by pointing to them as setting ideals of national, social and individual conduct aimed toward making life more worth while for more people than ever before. By that standard, our morals in practice, as well as our moral ideals, shine rather brightly against some rather dark spots in human history.

The race in general, and the peoples of the western world in particular, have made tremendous moral progress—and most social scientists will defend strongly the thesis that it *is* moral progress—in lessening the commonplace brutalities and the ordinary cruelties of the human world. It is true that we have not yet abolished wars and that we live today under the threat of an unthinkably destructive one, but most civilized peoples are ashamed of it. And although we have seen in our time what appear to be psychoses on national scales, with accompanying cruelties, it is at the

moment unthinkable that most nations or most individuals could engage in the sort of thing in which many of the world's peoples, including some of the greatest, took pride in the past.

These are such things as have mostly disappeared even from savage or barbaric practice, in our own day, such things as the collection of trophies from human dead. The Dyaks collected heads; the Jivaros still do. And the monarchs of one of the first of the great civilized societies also collected heads; they were piled high before the victorious Pharaohs as battle trophies. Many of the North American Indians and some other peoples collected scalps under similar circumstances; the ancient Israelites collected foreskins; the ancient Assyrians, testicles, as their battle sculptures give abundant testimony.

No civilized groups consider such conduct moral today; any civilized society would label the collecting of such grisly trophies highly immoral behavior. Neither would any modern society tolerate the once highly-moral custom of the annual human sacrifice of the "corn king" to insure the heavy yield of the crops and the blessing of the harvest gods; nor would any approve of once-pious parents who made their first-born "pass through the fire to Molech" in the invasion-threatened land of Moab, in war-imperilled Carthage, and in despairing, apostate Judah. We reject, without temptation, even without conscious consideration, conduct which our ancestors accepted as matter-of-course moral obligation. Human morals, in the sense that moral conduct reflects the greatest good for the greatest number—or the most lasting satisfactions, or the widest sympathies, or the most successful eradication of cruelties—have advanced immeasurably since the remote day when the first human scribe scratched down the first rude record of human accomplishment for later human generations to read.

One can belabor this sort of thing. Man's vastly lessened readiness to inflict death or physical torture on his fellows is one of many evidences of what in philosophical or theological terms could be called his greatly increased moral stature. This is not being unmindful—this generation can never forget them, and one may doubt if our children or our children's children ever can—of Hitler's mass murders and tortures, and the equally unspeakable atrocities of the Communist gangster-rulers of Europe and Asia. But the majority of the human race appears once to have engaged in this sort of thing; today's actual practitioners of mass murder

and torture are now in a small minority; the totals of those who support their monstrous power by approval, by acquiescence through terror, ignorance or indifference still do not approach the half of mankind. Today's vast majority regards such practices with extreme abhorrence and is deeply ashamed that there are human beings who engage in them.

Man has traveled a long and painful way from the times when defeated enemies were simply slaughtered, from the days when Roman triumphs saw helpless captives led between jeering crowds to be put to death painfully after the spectacle, and even from the days when the common man among the wounded of medieval battle had his throat slit and only those were spared who had prospects of paying ransom. It is brief in span of time, but long in distance indeed, from the point on man's upward climb where Moses—patriarch, framer of law and giver of religion, and one of the noblest figures in man's annals ordered the slaughter of the men-children and the women of Midian (Numbers 31, 17) and his army offered its golden loot to the Lord in thankfulness therefor.

Western man no longer holds his fellows in frank slavery—the end of it in America is still within living human memory. In Russia, where it is still practised in fact, there must be a sense of shame about it, for the fact itself is denied and slave labor euphemistically described as something else—or maybe as two or three other somethings. Rape is no longer regarded as the legitimate perquisite of the nobility or the conquering soldier; it is not regarded in our society as an acceptable act at any place or any time. Our armies are still trained to kill; but military law forbids (and our military leaders try to enforce the prohibitions) the looting, wanton destruction and the murder of civilians which used always to follow fighting—and still sometimes does, men being what men are, when there is disciplinary failure.

In our ordinary affairs, we take more care than used to be taken of our children. In most civilized lands, their exploitation by child labor is strictly forbidden, and their rights to food, shelter and educational opportunity are rigorously protected by law. We take more care of our elderly; in recent years, we have devoted much time and effort to thought for their care, financial security and happiness; and a whole new specialty of medicine is developing to meet their needs. And we take more care of our animals;

the anti-vivisectionists to the contrary, avoidable cruelty to an animal has changed from a usual to a very rare thing.

One can also see higher standards than used to prevail in our conduct of public affairs; one might not think so to read of this or that scandal in state or national government or of this or that alarming situation uncovered by some investigating committee; but we do not have today anything resembling the open corruption that was tolerated or at least shrugged off not too long ago. If we have vote-buying today, it is not public; if we do not always reapportion justly, we at least do not tolerate such things as England's famous "pocket boroughs" of a century ago; to Gerrymander is no longer something to boast about; thieves we still have in high places and probably always will; but, unlike the English in Pepy's day, we no longer expect the builders of our navies, and our power, to pay themselves by grafting—if they sin, they sin no longer with popular connivance.

All these things are matters that reflect human morality and human moral standards. They plainly add up to an enormous volume of testimony that the human race is pleasanter, easier to live with, and easier to get along with, than it used to be. And in all this, there has been (aside from the matter of rape) no mention of the particular field of morals which most people associate primarily with the word "morality"—the field of sex morals. The taboos, the superstitions, the religious prescriptions and prohibitions, the neurotic reactions and inhibitions that have surrounded man's sex practices in all the times we know of, veil any clear view of either practice or pretension; there can only be the most vague generalities. Even in our own day—and despite Kinsey—we know very little; we can only be sure that our actual behavior does not conform to the views we profess publicly. But we have little reason to believe that private behavior and professed belief have ever corresponded closely; and we have good reason to believe that both behavior, and ideals of what our behavior should be, have improved as the centuries have passed.

We do not, in our society at least, lock our women in harems to remain secluded, less than half-educated, treated like pet animals. We do not force our men—because of an artificial shortage of women—to be content with a fifth or a sixth of a wife each. We no longer expect women to be field or household drudges. We no longer discriminate socially, legally or in familial organization

against one sex or the other. As to physical relations between the sexes, the time when a woman was the property of any man strong enough to take her is lost in the dim mists of antiquity. The right of the nobleman to his serfs' wives and daughters disappeared long ago. Nowhere in the western world can the man of property buy slave women for the purpose of going to bed with them. And we seem to have broken the back of prostitution (of sex for hire) as big business; the argument that we must degrade a huge class of women "to protect our wives and daughters" from rape is seldom heard nowadays.

There may possibly have been times and places where both sex practice and ideals of what sex practice should be have made for happier and healthier people than we are today—it is a question one can leave for the moment to the anthropologist and the theologian. It is a question that is entirely beside the point here, for no such emotional Utopia is anywhere in western man's history; and the discussion here is not whether such a state of affairs can exist or ever has existed, but simply whether we, the people of the western world, have reached a moral stature in which to take pride or shame. From the general point of view, from an overall picture of man and his society, there seems little reason for shame.

There are many ways to look at man. One not too humorous distinction, between man and the rest of creation, is the description of man as "the cooking animal." In another view, man is the "time-binder." He is the creature with the capacity to evaluate and record the past and the present for the benefit of the future. Or he is the being with the immortal soul, a view the psychiatrist might do well to consider more than he sometimes does—however he may interpret it.

But man is also (and to his sorrow as well as to his progress) the moral animal. He is the only creature with morals of which we know, or of which man is ever likely to know unless he someday meets non-human intelligence on this side or that of Alpha Centauri. It is primarily as a moral creature that psychiatry deals with man. The well-adjusted man, who is psychiatry's goal, is the man who lives at peace with his morals. The man whose life and morals clash is the sick man we, as psychiatrists, treat.

It is a temptation to make too sweeping and too simple statements here. But by and large, the functional mental disorders, or

the functional accompaniments of the organic disorders, represent conflict between what man has done (or thinks he has done) and what his conscience, or moral principles, or super-ego tells him he should have done. Or they may represent the results of such conflict, manic triumph perhaps of id over super-ego, suicidal depression in the victory of the disordered super-ego over the id—or the split between mind and emotions, or between both of them and reality, that comes with retreat of the personality from conflict it cannot endure and cannot resolve. And so widespread as to include most of those we consider well, in addition to those we think of as mentally ill, are what might be called (maybe wrongly) such minor results of conflict, or of the ego trying to pacify the super-ego, or of the ego trying to atone for what it thinks are sins, as irrational fears, compulsions, rituals—the whole gamut of neurotic symptoms.

We think we, of all people, are equipped to testify to the extent and development of man's moral principles, to their indispensable values and their disastrous distortions, to the directing role that they play and always have played in the affairs of the human race. We think we are as well equipped as any to join in any general verdict on the present state of morals of the race; and we think, considering that man no longer eats his neighbors' brains, nails their scalps to his ridgepole, or thinks he has a right to rape and steal their women, that there has been at least some slight demonstrable improvement in humanity's moral standards since the cracked caps of the skulls of Sinanthropus were stamped into the cave floorings to provide the world's first grim human annals.

Psychiatry has abundant records and overwhelming clinical evidence to the effect that man's present moral standards are high and are general. There is an uncommon variety of individual (one type of the group usually called psychopaths) whom some believe to have no conscience; others of us think that, while this fellow's conscience is hard to locate and impossible to work with, the man who is truly without conscience simply doesn't exist. The ordinary person with whom psychiatrists come in contact has strong moral principles. It is one of psychiatry's difficult tasks to restore persons to health who are suffering because they imagine falsely that they have broken their moral codes, or because their consciences are so inflexible that they make capital crimes of misdemeanors. The psychiatrist may, on the one hand, seek to give in-

sight to the patient that no infraction of morals has occurred; or he may, on the other, attempt the immensely more difficult task of reconstructing the patient's conscience to permit toleration of activities generally accepted by both religion and society as normal.

In the ordinary course of growing up, one learns that people are not what they seem. One's respected teacher proves astoundingly misinformed; Honest John Jones, the butcher, is just far enough from honest to weigh his thumb now and then; and the revered and pious leader of one's Sunday school class deserts his wife and two small children and runs off with a waitress from the gin mill on the corner. This is the stuff out of which a person learns a most painful but most necessary lesson in cynicism. It is a necessary step toward becoming sophisticated, becoming a man or woman of the world, or at least one who understands something of the world. But if a person is eager and open-minded—and fortunate in his contacts and guidance—he may learn there are things behind and beyond cynicism, realities behind the false pretensions, the petty larcenies and misbehaviors that he, as a sophisticate, has learned to look for in mankind.

Conscience and moral principles can stand indestructably behind however an impressive a façade of the sillier varieties of human misbehavior. And the soundness of the construction is plain to see, both in times when crises throw great stress upon it and in the vast majority of the basic (not the façade of the false-faced) activities of mankind. It may be doubted if there is anybody in psychotherapy who—however disillusioned by the tragedies and failures—has not been impressed by the indomitable spirit and the high moral aims embodied in a conscience that has raised man from the caves of Chow Kow Tien to a level which, if not at the ultimate moral heights, is one where we at least try to see our fellow-men as our brothers.

There are too many in our age, as there have always been in other ages, who deplore our times and our behavior. We may feel ourselves that we could improve the times; we agree as to the need of improving the behavior; but we do not leap from the simple observation that our morals might be better to the *non sequitur* that they are in a desperate state. As a professional group that not only has ordinary contacts with man's superficial behavior, but sees daily evidence of the qualities of his strivings and his strengths besides, psychiatrists might consider whether they are

not under something of an obligation to note their clinical findings to the contrary when others evidence too sour a view of the good intent and the earnest endeavors of the human race. At any rate, it would seem that we have a certain duty to those in other disciplines who display the insight to support publicly a not-too-popular viewpoint that the daily work of psychiatry demonstrates is correct. When such a group as the three-day conference on moral standards, whose conclusions inspired this discussion, can go on public record to the effect that the state of man's morals—although in condition for improvement—is good, we think it calls for equally public approval on the part of the people most thoroughly informed and most intimately concerned. For psychiatry's part, we think we can express agreement here and now.

BOOK REVIEWS

Symbolic Realization. A New Method of Psychotherapy Applied to a Case of Schizophrenia. By M. A. SECHEHAYE. Monograph Series on Schizophrenia No. 2. Translated from the French by B. and H. Würsten. 184 pages. Cloth. International Universities Press. New York. 1951. Price $3.25.

In this work, the psychologist-author examines and interprets the steps taken by her in the role of therapist of a schizophrenic girl, Renée. After Madame Sechehaye found that her verbal explanations of Renée's thoughts and symptoms were confusing and exasperating to her patient, that this type of treatment did not touch the structure of the psychosis, she decided to "speak to her in her very own language [p. 13]." Up to that point Renée was satisfying her at first repressed, then persistently reappearing demands, by means of deliria and hallucinations.

The therapist then changed the approach, and proceeded to calm the patient and to aid her in giving those demands real and concrete satisfaction. One illustration of this dramatic symbolic realization may suffice: After three years of treatment the therapist had not been able to help much. But she had learned to understand what Renée was waiting for, that she wanted apples (the maternal breast) to be given to her like milk to a baby, little quantities at a time, and at fixed hours. By feeding Renée bits of apples during her therapy sessions, the "new mother had proven that she wanted her child to live and the child's confidence is able to assert itself. . . . The first obstacle has fallen, Renée is able to continue the evolution that will later on lead to the foundation of the superego [p. 53]." As the girl's trauma had occurred during the pre-verbal stage, the method of symbolic realization was useful, because it was primitive, the author holds. Many drawings with legends are reproduced in the book's anney, giving a vivid picture of the fears and the self-punishment the patient must have undergone. The reader will follow with intense interest the account of the years during which Renée, who since has remained a healthy, mature and brilliant person, found through symbolic realization, not only relief, but contact with reality.

Captive Surgeon. By ERNEST M. LIPPA, M. D. 280 pages. Cloth. Morrow. New York. 1953. Price $4.00.

This is a story of the "adventures and misadventures of a doctor in Red China." It is honest description, since the author lived his tale. Primitive conditions seem to fascinate him, most of the book being concerned with them. This is a pretty good book to relax with and read for enjoyment. It is not by any means unique.

Modern Clinical Psychiatry. Fourth edition. By ARTHUR P. NOYES, M. D. 609 pages including index. Cloth. Saunders. Philadelphia and London. 1953. Price $7.00.

The complexity and tenuousness of psychiatric precepts makes compilation of complete, yet concise and understandable, psychiatric textbooks very difficult. In this edition, the author has been more successful than previously, in arranging his text in such a manner that one can progressively build up his basic psychiatric knowledge by reading the book but still be able to find specific topics for reference, rapidly and conveniently.

The fourth edition is larger and more comprehensive than the previous one. The increase is a result of the addition of new or larger sections on psychotherapy, the organic therapies and the psychological concepts of mental illness. The author commendably maintains a reasonable balance in his presentation of the various idealogies in present-day psychiatry. This work should prove to be a valuable one for any psychiatrist.

Men of the Underworld. The Professional Criminals' Own Story. Charles Hamilton, editor. 336 pages including glossary and index. Cloth. Macmillan. New York. 1952. Price $4.50.

In the present-day era of syndicated crime, televised investigations, and the "respectable" gambler, the "big time" criminals of past years have been all but forgotten. This book is a very interesting dissertation on the personality types, thinking, and methods of many of the famous American criminals of the past, from Horse Thief Henry of the 1740's to confidence man Joseph "Yellow Kid" Weil of recent years. Gambler, counterfeiter, prostitute, forger, fence; it includes the notorious of them all, telling, often in their own words, the how's, why's, and wherefore's of crime up to the post-war era. It ends with a very pertinent admonition that crime doesn't pay—usually—and that a change in the social attitude toward crime is imminent.

Mothers on Their Own. By ELBURN ROCHFORD. 210 pages. Cloth. Harper. New York. 1953. Price $2.75.

This is a guide book for those unfortunate mothers who, for one reason or another, find themselves without a husband. It is simple and concise and in this lies its one main fault. It is too concise. It is concrete and unwavering. Budgets and expenditures, clothing and entertainment are all set down with stipulations concerning almost all aspects of life. All are cold do's and don't's.

Other than this lack of feeling, probably in itself necessary, it is obviously a well worthwhile book for the needy woman with children.

Les Regulations Neuro-Vegetatives. By SANDRO BURGI. 173 pages. Doin. Paris. 1953. Price 680 fr.

The autonomic nervous system has acquired an increasing importance with the increase in knowledge of neurophysiology and a better understanding of the many mechanisms governing mental life. To present a synthesis of the knowledge thus far acquired, to comment on its implications and stay objective is not an easy task. We are indebted to Professor Burgi for a monograph that fulfills the hopes of the reader. Professor Burgi has done research directed both by Professor Lhermitte of Paris and Professor Hess of Zurich. His documented presentation will be useful not only to specialists in neurophysiology or neuropathology, but also to every psychiatrist who, as suggested in the preface by Lhermitte, does not separate, as if they belong to different compartments, autonomic activity from mental functions.

The conditions regulating the autonomic nervous system are influenced by the purpose to be achieved, and one thus speaks of a retroactive finalism. However the study of such purpose is beyond the object of Burgi's book. The mechanisms of the autonomous life are but means and methods to allow the organism to achieve whatever purpose will retroactively affect the conditions initiating the reactions. Thus it is strictly from a biological and functional point of view that this study is made. "The autonomic regulations adjust the functioning organ to varied conditions, external or internal, in order to reach a goal and safeguard homeostasis" (p. 13). These organs "possess a relative autonomy and are equipped with their own pacemaker."

It is from such an approach that the author first discusses the organization of the autonomic nervous system itself. Then in the following chapters, he covers the functioning required by the processes of feeding, water metabolism, oxygen consumption, thermoregulation, the reproductive system, the organs of perception.

Finally, the last two chapters deal with the concept of level of functioning. "It appears safe to state that in the meso-diencephalon, there are regulators adjusting the autonomic and perhaps the motor innervation to allow a normal physiological expression of instinctual demands. There also exists an organization prompting the autonomic system to influence previously regulated organs and thus safeguard an adequate water metabolism, a constant temperature and perhaps a complete sexual cycle. However, many links are missing and long and patient experiments are needed." The regulations at the cortical level are divided into five groups, but "there seems to be no evidence of a superior level of functioning." The monograph includes an extended bibliography useful for future references.

Cardano the Gambling Scholar. By Oystein Ore. 249 pages including index. Cloth. Princeton University Press. Princeton, N. J. 1953. Price $4.00.

Girolamo Cardano was one of the strangest men of genius or near-genius in the annals of science. One of the most distinguished physicians of the sixteenth century (considered by many second only to Vesalius), Cardano was a gambler, a mathematician, a writer of hypomanic tirelessness and possibly a bit of a charlatan. His medical career opened with public humiliation for his illegitimate birth. An embittered critic of the doctors of his day, he was admitted grudgingly to practice and at once reached eminence.

He is remembered even better today for his extraordinary achievements as a mathematician; and Ore, incidentally, acquits him of the charge frequently made that he stole the rule for solving the cosa and cube equation from Niccolo Tartaglia. Cardano's famous book on gambling, translated by Sydney Henry Gould under the title of *The Book on Games of Chance*, is included in the present volume. Cardano's personal life alternated between achievement and the most unpleasant vicissitudes. He treated Archbishop John Hamilton of Scotland successfully for asthma by methods which any modern allergist would approve, but he cast a most unfortunate horoscope for the boy king, Edward VI of England. He certainly engaged in what his contemporaries considered black magic.

Cardano's autobiography, written in extreme old age, indicated that he had hallucinations at various times in his life, and many other aspects of his personality and career make him an excellent subject for study by the psychiatrist. Incidentally, Ore says, he showed more than ordinary ability as a psychiatrist himself.

The University of Utopia. By Robert M. Hutchins. 103 pages. Cloth. The University of Chicago Press. Chicago. 1953. Price $2.50.

Robert M. Hutchins was once known to certain derisive critics as the boy wonder of education. He had ideas; some were radical; and their effect on the University of Chicago is still a matter of debate. Whether or not Hutchins has changed his views he has at least changed his emphasis.

The University of Utopia, representing the Walgreen Lectures at the University of Chicago in 1953, is from the point of view of this reviewer on the side of the angels. Hutchins stresses the importance of the content of education, of the freedom of expression in education, of emphasis on communication (English and so on) and, perhaps above all, of training in the habit and capacity to think.

This book is to be recommended for study by professional people and others who feel uneasily that something is wrong with our higher education and are not quite sure what it is.

Divine Horsemen. By MAYA DEREN. 350 pages including index. Cloth. Thames & Hudson, Inc. New York. 1953. Price $4.75.

Maya Deren is an artist and the daughter of a psychiatrist, and both artistic and psychiatric insight into Voudoun are evident in her *Divine Horsemen*. The divine horsemen are the *loa*, the divinities or spirits who "possess" or ride their devotees as a horseman rides a horse. Voudoun, Miss Deren finds, is not the congeries of miscellaneous African and Christian beliefs, thrown into a crude and primitive setting, which is generally supposed. It is a highly-organized and, this reviewer would think, a sophisticated mythology to which all of Haiti but the self-styled aristocrats are devoted.

Miss Deren lived with the Voudoun worshippers, first as an artist, then as a most understanding and sympathetic observer. Other observers have concluded that the Christian Church has tolerated Voudoun as a superstition of believers; Miss Deren's work suggests the contrary is true.

This is as detailed a study of a contemporary mythology as this reviewer has seen recently. It has a certain amount of practical interest, as there are surely adherents of Voudoun, possibly in a corrupt form, scattered throughout the United States. The account of religious "possession" is of considerable psychological and psychiatric interest.

The Doors of Perception. By ALDOUS HUXLEY. 79 pages. Cloth. Harper. New York. 1954. Price $1.50.

This short book is the account of a fantastic excursion by Huxley into the wonderland of mescaline intoxication. He enjoyed it, as most of the general public now knows from reviews and other reports of this little work. His thesis is: "That humanity at large will ever be able to dispense with Artificial Paradises seems very unlikely." He thinks mescaline provides a comparatively harmless artificial paradise and a considerably more paradisical one than most.

This reviewer thinks that in the present state of our scientific knowledge —or perhaps lack of knowledge—this is a very dangerous little piece of work. He will not debate whether mescaline can cause addiction or whether it has harmful physical effects; but he thinks that this book and the reputation of this book are calculated to encourage addiction to other drugs when experimenters find that mescaline is not available. The reviewer suggests that not only psychiatrists but all others concerned with the problem of addiction—from magistrates and institution staff members to parole officers —might do well to familiarize themselves with its content. He hopes Huxley will return to *belles lettres* and novel writing.

Therapeutic Abortion. Harold Rosen, Ph.D., M. D., editor. 348 pages including index. Cloth. Julian Press. New York. 1954. Price $7.50.

Rosen's book is a reference text on the principal aspects of therapeutic abortion. It presents material from legal, theological, psychiatric and psychoanalytic sources. The authorities are for the most part excellent. The editor is a psychiatrist and this is the first reasonably complete psychiatric presentation of the subject this reviewer has seen. It covers such related problems as discussion of emotional concomitants, sterility, infertility and the psychological significance of vasectomy.

This volume should be of use in any institutional library.

Trial of Jeannie Donald. J. G. Wilson, editor. 305 pages. Cloth. British Book Centre. New York. 1954. Price $3.25.

Twenty years ago Mrs. Jeannie Donald of Aberdeen became annoyed at an eight-year-old neighbor girl. She took her by the throat and shook her; the child had an enlarged thymus gland and became unconscious; Mrs. Donald thereupon, assuming she was dead, mutilated the body to make it appear that the little girl had been attacked by a rapist.

Her trial is worth study as having developed an unusual amount of medical testimony. Incidentally, Mrs. Donald was convicted of murder—the book suggests that this was largely because she lied to the police; she was sentenced to death but the sentence was commuted.

From Fish to Philosopher. By Homer W. Smith. 264 pages including index. Cloth. Little, Brown. Boston. 1953. Price $4.00.

Smith reviews evolution for the general reader and the student from a most unusual point of view—the development of the kidney, which he traces from primitive fish to man. Almost any scientist and surely any physiologist will find this discussion of considerable interest. It is somewhat too specialized, however, to be an acceptable substitute for the usual texts.

Sex and Marriage. By Havelock Ellis. 219 pages. Cloth. Random House. New York. 1952. Price $3.00.

Sex and Marriage is a presentation of unpublished or uncollected papers left by Havelock Ellis when he died in 1939. It is probably fair to say that there is nothing new and nothing surprising in them although Ellis' views of Westermarck and Freud may be more clearly expressed here than elsewhere. Some of the rest of the material is outdated in view of the last 20 years of both social and psychiatric research.

This volume will be of chief value to the collector of Ellis' works who wishes to complete his library.

Educating Gifted Children. By GERTRUDE HOWELL HILDRETH. 272 pages including index. Cloth. Harper. New York. 1952. Price $3.50.

This book is more than a log of a new experiment in education. In the opinion of the author, the assets and capabilities of gifted children are too many to be wasted in a traditional educational program.

Gifted children may be considered in two groups: those that are intellectually gifted and those that are specifically talented. In the first group, are those who rate high on intelligence tests, and in the second, are those whose talents are in a specific field. At Hunter Elementary School, which is a part of Hunter College (the college for women maintained by the City of New York), children are selected on the basis of a psychological examination and an evaluation of the child's personal behavior.

The program at the school includes a wide curriculum, and the child is exposed to as many things as he can grasp. The class rooms are handled by experienced "gifted teachers" and the atmosphere in a room is of the informal, workshop type. Learning is achieved through direct experiencing. Traditional school subjects are combined with new methods and equipment to promote high motivation and learning efficiency.

To help children with personal problems, a program of mental hygiene exists, along with an integrated program of activities among teacher, pupil, and parent, and the school and the community.

The book provides, for both professional people and parents, ideas on how to expose a child to all types of enriched educational experiences.

The Deep Sleep. By WRIGHT MORRIS. 312 pages. Cloth. Scribner's. New York. 1953. Price $3.50.

The author has acquired some reputation as "interpreter of those tangents of the American scene where the funny and the pathetic collide." Putting this reputation to test in the present volume, one finds neither fun, nor psychologic understanding; the pathetic (death of a judge) is described with such complete coldness as to make one wonder whether the old dictum that the writer has to evoke feeling that the reader can use for identification is still accepted among the younger generation of writers.

Six Angels at My Back. By JOHN BELL CLAYTON. 200 pages. Paper. Macmillan. New York. 1952. Price $1.50.

A journalistically perceived, and journalistically executed novel concerns three juvenile delinquents. The author's idea of the motivation of crime is based on psychological ignorance. It is devastatingly simple: "I been kicked around just about long enough."

Psychoneurotic Art: Its Function in Psychotherapy. By MARGARET NAUMBURG. x and 148 pages. Cloth. Grune & Stratton. New York. 1953. Price $6.75.

This is a case study of a young woman who was treated successfully for compulsive eating, compulsive masturbation, and daydreaming. The method was the study and interpretation of her art productions. Sixty-five of them are illustrated, some in full color, in this book. The data assembled from the patient's interpretation of the drawings and verbalizations of conflicts was correlated with the Rorschach findings of two clinical psychologists. The author places a great deal of emphasis upon the psychotherapeutic effects of art therapy alone, with only occasional assists from more conventional analytic methods. While the material in this study is definitely Freudian in scope, she believes "The spontaneous interpretations of their own symbolic art given by patients during the process of art therapy tend to confirm not only the psychoanalytic concepts of Freud but also those offered by Jung and Sullivan."

Power of Words. By STUART CHASE. 308 pages including index. Cloth. Harcourt, Brace. New York. 1953. Price $3.95.

Stuart Chase wrote the widely-known and very useful *Tyranny of Words* some 15 years ago. When he decided to revise it, the revision grew into an entirely new book, the present volume. Chase covers rather briefly the enormous field of communication, including such topics of particular interest to psychiatry as general semantics, propaganda, "gobbledygook" and group psychotherapy. For this last he calls largely on the experiences of Dr. Douglas M. Kelley.

This book should be of value to any psychiatrist who is interested in: the orientation of his own specialty in relation to science in general; the improvement of communication within his own specialty and with other scientists; and the relation of communication difficulty to mental and emotional disorder.

The Urge to Persecute. By A. POWELL DAVIES. 219 pages including index. Cloth. Beacon Press. Boston. 1953. Price $2.75.

This is a short but eloquent exposition of the phenomenon of persecution for expressing nonconformist ideas. The author is the pastor of a Washington church. His scene is present-day Washington. Much of his material is clinical; that is, it comes from interviews in the course of pastoral counseling. The book is descriptive, however, rather than analytic. Despite his best efforts, and he does not ignore the subject, he does not make quite clear why the persecutor ticks. It is nevertheless a text worth reading and worth quoting: "Those who are truly against tyranny are against *all* tyranny."

Ghosts and Poltergeists. By HERBERT THURSTON, S. J. 210 pages including index. Cloth. Regnery. Chicago. 1954. Price $4.00.

This compilation of incidents from the writings of Father Thurston is concerned chiefly with poltergeist phenomena. He describes himself as a "firm believer in the reality of poltergeists and in the impossibility of finding any natural explanation of their recorded activities." The selection of material is excellent and much of it is not readily accessible elsewhere. Father Thurston's explanation, of course, is supernatural. He questions whether they are the "work of the devil" but notes that "the exorcism and comminatory rights of the Church are not always, or indeed generally, effective in putting an end to poltergeist disturbances. . . ." An interesting appendix gives the exorcism for haunted houses as published with the authorization of the Council of the Inquisition in 1631.

An Analysis of the Kinsey Reports on Sexual Behavior in the Human Male and Female. Donald Porter Geddes, editor. 319 pages including index. Cloth. Dutton. New York. 1954. Price $3.50.

Donald Porter Geddes has added another to the numerous reports and analyses issued as a result of the Kinsey surveys of sexual behavior in the human male and female.

This is a wide selection from interested persons, ranging from psychiatrists and clergymen to anthropologists, marriage counselors and college presidents. The editor's introduction states: "Numerous as are the objections to Kinsey's findings, there are few claims that what he is revealing is not so." The unreliability of sex questionnaire data has, however, been the chief point of attack by psychiatrists, particularly psychoanalysts. A volume which by-passes conspicuously this point of view is unlikely to find enthusiastic recommendation from the mental specialists.

Psychics and Common Sense. By WILLIAM OLIVER STEVENS. 256 pages. Cloth. Dutton. New York. 1953. Price $3.50.

The author of this book points out that there are recognized gaps in scientific knowledge and that one cannot dismiss phenomena simply because one cannot explain them. He thereupon sets down a record which ranges from ESP material of respectable background to a collection of incidents which are generally credited only by the spiritists. The compilation is of interest, of course, to anybody concerned with the ESP fringe of psychiatry.

Les Nerfs Craniens. By RENÉ-MARCEL DE RIBET. 568 pages. Doin. Paris. 1952. Price 3,500 fr.

This textbook is presented as an outline for reference and for didactic purposes on the anatomy of the cranial nerves. Such a statement may give an impression of incompleteness that would not do justice to the author. The 12 pairs of cranial nerves constitute an elaborate structural and functional system that would need more than one volume for complete presentation, if one were to include every problem now under scientific scrutiny. This book deals with the material necessary for those involved in fields other than research and teaching.

The content is divided into three sections. The first includes a general understanding of each nerve pair through a presentation of structure, localization and embryology. The second contains a detailed description of each pair. The third consists of a series of illustrations which this reviewer would consider original. The book is a good adjunct, not only for didactic purposes, but also for quick reference.

The Best Years of Your Life. By MARIE BEYNON RAY. 300 pages. Cloth. Little, Brown. Boston. 1952. Price $3.95.

This volume is "inspirational" material for those who fear their lives will be incompletely fulfilled and for those pensioners who are dying of apathy. It contains many interesting anecdotes about famous persons who have remained creatively productive to their tenth decades, but there are too few examples of lesser individuals who have remained similarly productive in their own spheres.

Numerous agencies, schools, and societies in the New York metropolitan area are listed, but the scope of the book would have been much increased by the inclusion of reference material pertaining to other major cities.

Pediatric Problems in Clinical Practice. H. Michal-Smith, Ph.D., editor. 310 pages. Leatherette. Grune & Stratton. New York. 1954. Price $5.50.

This book is a good foundation for explanation to parents by those to whom sick children are entrusted, especially the nurse. It too is useful to the doctor as a ready and reliable reference manual. Its content ranges from discussions of the normal child to the cardiac, brain injured, diabetic, epileptic, emotionally disturbed and the allergic.

Short Dictionary of Mythology. By PERCIVAL GEORGE WOODCOCK. 156 pages. Cloth. Philosophical Library. New York. 1953. Price $3.75.

This is more an incomplete classical than a mythological dictionary. The definitions, as well as the book, are short; and some are of doubtful accuracy. It, nevertheless, could be used as a reference book for persons having occasion to look up the mythological background of present-day thought, although better reference volumes are available for the purpose.

Should I Retire? By GEORGE H. PRESTON, M. D. 181 pages. Cloth. Rinehart. New York. 1952. Price $2.50.

This book is designed to answer the layman's questions regarding the question of retirement. With the increasing stress being given the problem of our aging population it is particularly appropriate. The author does not avoid the more unpleasant aspects of the subject, and for this reason the book may be found somewhat depressing by some readers. It is time, however, that a realistic approach was taken toward the problem—uncolored by excessive sentimentality. The psychological problems concerning the aged are recognized and given their full importance.

Helping Parents Understand the Exceptional Child. Proceedings of Conference on Education and the Exceptional Child of the Child Research Clinic of the Woods School. 42 pages. Paper. The Woods School. Langhorne, Pa. May 1952.

This is another booklet in The Woods School series on understanding mental deficiency. The mental defective is a person, not an IQ rating. The education of parents, medical personnel, educators and all concerned is needed for awakening to the psychologic problems involved. Several papers relating to the "exceptional" child are presented by such leaders in the field as Leo Kanner, M. D.

Born a Yankee. By GRACE CARSTENS. 250 pages. Cloth. Macmillan. New York. 1954. Price $3.00.

A novel of traditionally rigid New England standards is presented by the author. It is very easy reading. It is doubtful that such a person as Kate Fyfe ever existed, for such stereotyped psychological problems as hers seldom are found. However, many will envision their own martyrdoms and disappointments in her.

Breakthrough on the Color Front. By LEE NICHOLS. 235 pages. Cloth. Random House. New York. 1954. Price $3.50.

This is one of the most objective reviews of the color problem yet produced. It is a statistical review of the integration movement of white and colored service men, begun very casually in the armed services during the Civil War and extended to complete assimilation at present.

Lee Nichols is a newspaperman, a rewrite man for United Press covering the House, Senate and State Department. The basic facts came from the Pentagon for this behind-the-scene story.

Clinical Management of Behavior Disorders in Children. By HARRY BAKWIN, M. D., and RUTH MORRIS BAKWIN, M. D. 495 pages. Cloth. Saunders. Philadelphia and London. 1953. Price $10.00.

This book is designed as a practical guide for the physician, child psychologist, and all workers in the field of child guidance, as well as the psychiatrist. For this purpose, the volume has been divided into sections covering such aspects as "Growth and Development," "Care of the Physically Ill and Handicapped Child," "Problems of Habit and Training," as well as "Diagnosis and Treatment of Behavior Disorders in Children," and "Problems Related to Emotional Development."

Emphasis is laid on practicality and practicability; specific situations are discussed; and preventive or therapeutic measures are suggested. Comparisons between the normal pattern and the pattern under discussion bring the pictures of pathology into a clear sharp focus against the background of experience. The language in which the entire volume is written is extraordinarily clear and simple, making it pleasurable, as well as profitable, reading. This book could well be recommended to the novice in the field of child care, as well as to the seasoned specialist.

The Conception of Disease. Its History, Its Versions and Its Nature. By WALTHER RIESE, M. D. 99 pages. Cloth. Philosophical Library. New York. 1953. Price $3.75.

This is a scholarly presentation of the history of the concepts of disease, mental and physical. Beginning with the Stoic concept it traces through the Platonic, the moral, the Hippocratic, the anatomical, the social, the psychological, the biographic and the metaphysical beliefs relative to the origin and causation of disease.

As one reviews with the author these historical concepts of disease one realizes that today's concepts are not new and are not divorced from the past. The concept of disease in the middle twentieth century is a mixture of previous concepts and these previous concepts very much influence one's thinking and reasoning today.

Scylla. By MALDEN GRANGE BISHOP.

Waltz Into Darkness. By WILLIAM IRISH. Paper. "Two complete Novels." Ace Books. New York. 1954. Price 35 cents.

Apprehension has been expressed by friends of literature lest the 35-cent book lower literary standards, since this type of publication must appeal to a very large audience. The two "novels" cited here seem to confirm the worst expectations: Two murderers are depicted who murder "for money." One cannot say that these expectorations are without psychological motivations; the authors merely write as if only the most naïve motivations from the sphere of consciousness exist.

The Psychoanalytic Study of the Child. Vol. VII. Ruth S. Eissler, M. D.; Anna Freud, LL D.; Heinz Hartmann, M. D.; and Ernest Kris, Ph.D, editors. 448 pages including bibliography and index. Cloth. International Universities Press. New York. 1952. Price $7.50.

This book is divided into two parts, the first of which deals with various aspects of the development of the Ego and the Id. It presents in book form, a symposium held at the Seventeenth Congress of the International Psycho-Analytical Association in August 1951. No new ideas are expressed here, and the style is rather rambling, disjointed, and ruminative. If anything, it detracts from the interesting and thought-provoking second part.

The second section is a practical dissertation on several situations which are prone to initiate emotional disturbances in children. Illness, operations, animals, masturbation, teasing, loss of a parent, etc., are discussed from the standpoint of analytical dynamics and analytically-oriented therapy. Child rearing, common difficulties in children, and other basic concepts in child guidance and therapy are also presented. All in all, the second part of this book is very worthwhile reading.

God's Country and Mine. By JACQUES BARZUN. 344 pages. Cloth. Little, Brown. Boston. 1954. Price $5.00.

As usual, Barzun has turned out a magnificent piece of literature. It is "a declaration of love, spiced with a few harsh words." It is honest, witty, dramatic, poetic and easy reading.

"The mind of man can fashion a directed missile that will hit the enemy in the left eye but cannot make a schedule for New York buses." "What is clear is that all drivers hate the public and rejoice in their discomfiture and delay." And: "We would settle for Hell as our next stopping place: living conditions could be no worse there, and the climate would be better for our sinuses."

He traipses gaily from doctors to tunnels; to statistical living; to American slang. He obviously is in love with the United States.

Satan in the Suburbs. By BERTRAND RUSSELL. vii and 148 pages. Cloth. Simon & Schuster. New York. 1953. Price $3.00.

Why did Bertrand Russell have to wait until he was past 80 to start writing fiction? Couldn't he have slipped in just a few short stories among his multitudinous books on philosophy before this? These stories, written in a purposely archaic semi-Gothic manner, provide a refreshing change from much of the ultra-modern writing of today, and prove again that good writing, within limits, cannot be dated by style. The themes throughout are fantastic, and should be treated as such, rather than searched for "deeper meaning."

The Technique of Psychotherapy. By LEWIS R. WOLBERG, M. D. 874 pages including index. Cloth. Grune & Stratton. New York. 1954. Price $14.75.

In this monumental, eclectic presentation of psychotherapeutic methods, the author very adroitly fuses many therapeutic concepts into a practical technique. He readily admits that psychotherapy cannot be stereotyped but emphatically insists that certain basic tenets are essential to successful therapy: (1) Therapy must be goal-directed toward specific objectives. (2) It must be organized around a relationship between therapist and patient. (3) Some kind of interviewing proceeding must be adopted. (4) An emotion response must be evoked in the patient which the therapist must adequately handle.

Specific direction is given as to how to begin, continue and terminate psychotherapy. The various types of psychotherapy (directive, supportive, etc.) are described and exemplified. This voluminous work fills a very definite need for a good primer in psychotherapeutic technique.

A Way to the Soul of the Mentally Ill. By GERTRUD SCHWING. 158 pages. Cloth. International Universities Press. New York. 1954. Price $3.00.

Mrs. Schwing published this book some 14 years ago in Germany, and it has since become famous on the continent.

For the psychiatric nurse, this book is invaluable. In it, Mrs. Schwing emphasizes the tremendous importance of motherliness, and its effect upon those (and she implies that the lack of mothering is *the* cause of all schizophrenias) who have never been touched deeply or steadily by it.

Though not absolutely contemporary, this book should be in every psychiatric library, for the author seems truly to have found "A Way to the Soul of the Mentally Ill."

Jemmy Button. By BENJAMIN SUBERCASEUX. 382 pages. Cloth. Macmillan. New York. 1954. Price $4.00.

Here are the translated words of the man who writes of the transplantation of Jemmy Button and other Fuegian natives to the civilized, and therefore "better" world of Britain. The story covers the problems of this experiment, and the outcome, which is the real story beautifully told. It is based in part on Captain Fitz-Roy's *Diary* and Darwin's *Voyage of the Beagle*.

The story is a combination of a fertile imagination and fact. It is a sea tale; and a study of integration, love, sensuality, horror and death, well told and worth while.

Hypnotism. An Objective Study in Suggestibility. By ANDRÉ M. WEITZENHOFFER. 341 pages. Cloth. Wiley. New York. 1953. Price $6.00.

All persons interested in hypnotism will find in this book a comprehensive evaluation of that subject. The author has collected much material long forgotten and scattered in numerous references.

The book offers a review of the basic experimental ideas of hypnosis; the phenomena which have been demonstrated through hypnosis; the recent theories relative to the mechanisms through which hyper-suggestibility is produced; and, finally, a summary of the facts and the author's own formulations.

The book emphasizes that hypnosis is far less spectacular and less magical than it was once thought to be. It notes "that the differences between hypnotic and waking phenomena are essentially quantitative and not qualitative . . . that there are no a priori reasons to expect that the phenomena evoked in hypnosis should be physiologically or even psychologically different in any fundamental way from those seen under otherwise similar conditions in the waking state. It appears now that we can state with some reason that one possible interpretation of hypnotic phenomena is based on the postulate that hypnosis does not alter the basic psychophysiological processes which underlie similar functions in the waking and the hypnotic state, nor does it create new mechanisms. In other words, psychophysiological phenomena are *invariant* in respect to hypnosis. . . ."

The book has a large bibliography, listing 508 references plus complete indices for authors and for subjects.

Mental Health in the Home. By LAURENCE SPURGEON MCLEOD, Ph.D. 243 pages. Cloth. Bookman. New York. 1953. Price $3.50.

Though this book has little, if any, new information to add to what we already know, and is at times repetitious and a bit naïve, it can be a help to the new (or for that matter, the old) parent or mate, to solve some of the problems that present themselves daily in the family. The suggestions are sensible, but there is an amazing lack of analysis of motive. Perhaps Dr. McLeod feels the average parent could not follow this type of material. Thus the work is a good guide book, but lacks background.

Medical Progress 1954. Morris Fishbein, editor. 345 pages. Cloth. Blakiston. New York. 1954. Price $5.00.

Medical Progress 1954 is a comprehensive summary by 28 authorities of the significant advances in the medical field during 1953. The section on psychiatry is by Francis J. Braceland, M. D. Fishbein himself gives an over-all synopsis at the end of the book. It is a worthwhile short reference volume of well-gathered and composed information.

Symposium on the Aetiology and Psychopathology of Peptic Ulcer. Christchurch Psychological Society. Christchurch, N. I., New Zealand. 73 pages. Paper. March 1952. Price not given.

This is the written work that came out of a New Zealand symposium on peptic ulcer gathered by the Christchurch Psychological Society in Christchurch, N. I., August 18-23, 1951. It includes the opinions of physiologists, medical men, psychiatrists, psychologists and pathologists from many commonwealth nations. Quotations are taken from many British and American journals. Besides opinions, there are many case histories. The whole report is interesting and is illustrative of prevalent British philosophical psychology.

Some Rights of Children. By PHILANDER PRIESTLEY CLAXTON. 82 pages. Cloth. Exposition. New York. 1953. Price $2.50.

In this brief and simply written book the author has catalogued what he refers to as the "rights of children," rights which he hopes will serve as a general guide for teachers and parents in their understanding of children's relationships to their world. In the form of summaries, devoting about a page to each "right" discussed, the author considers such topics as the right of the child "to be well born," "to respect for silence," respect for "ownership," "for pets and companions," etc. Primarily oriented toward the educational program, the author emphasizes what the environment may do for the child in making available to him, the "inalienable rights," that provide for secure, mature, development of the personality.

Progress in Neurology and Psychiatry. An Annual Review, Volume III. E. A. Spiegel, M. D., editor. 575 pages. Cloth. Grune & Stratton. New York. 1953. Price $10.00.

This annual summary of literature in neurology and psychiatry grows slightly larger each year, as international communications have increased since World War II. Also, because of this increase, the editor has had to become more selective in his collected material. He has allotted the major part of the book to clinical neurology and psychatry (about 416 pages) while the remainder relates to neuroanatomy, neurophysiology, neuropathology and neurosurgery. In all over 3,200 papers have been reviewed.

As in the previous volumes, most of the papers have been reviewed very briefly, but the book is a "storehouse" of information. Following each chapter, the references are listed in detail, so that a person can easily refer to the original papers.

Dr. Schmidt's Sex Dictionary. And Lexicon of Related Emotions. By J. E. SCHMIDT, M. D. 106 pages. Paper. Hannah Publications. La Crescenta, Calif. 1954. Price $1.00.

Dr. Schmidt is described in the publisher's introduction as a graduate in pharmacy, a physician, lexicographer and enthusiastic coiner of neologisms. Maybe this combination is responsible for his book's patent medicine title, or maybe Dr. Schmidt is also a joker. Somebody is a joker, at any rate—or maybe a product of "modern education"—for this remarkable "dictionary" is put together with small regard for the alphabet. (The author and publishers say that since the words are new, nobody will be looking for them anyway, so they have put them together in a "pattern of related thoughts"—groupings in which there is logical instead of alphabetical sequence.) The result is a vocabulary that opens with "callicolpia"; has "ablutophilia" following "zooerotism" on page 34; and closes with "colpofette" and "philamette." The joke, if any, will be on the disappointed seeker for erotica, or maybe on the purchaser for serious study, unless this review is a warning. If the whole thing is, by chance, all intended as good, clean fun, this reviewer's opinion is that it is vastly overpriced at a dollar.

Dr. Schmidt's publishers note that he is interested in mechanics, electronics and other matters scientific besides those already noted, and that he is now "engaged in work covered by security regulations." One hopes this work is not the preparation of a sequel.

Hope and Help in Parkinson's Disease. By JOHN C. BUTTON, Jr., M. D. 198 pages (includes: 99 pages text; 3, questions and answers; 13, biography; 36, James Parkinson's *An Essay on the Shaking Palsy*; 44, bibliography; 3, index). Cloth. Vantage. New York. 1953. Price $4.95.

This is the only complete coverage of Parkinsonism to come out for the layman. It is thorough, simple and straightforward. Though primarily for the general public, its coverage is complete enough to make it worth while for the physician and nurse. Its honesty will be most appreciated by those suffering from this too seldom well-explained disease. It can stand as a standard for what laymen's medical literature should be.

The Neurotic, His Inner and Outer Worlds. By JOSEPH B. FURST, M. D. 267 pages. Cloth. Citadel. New York. 1954. Price $3.50.

This book is described on the dust cover as "a rational approach to the causes and treatment of neuroses." There is comprehensive coverage of neurotic behavior at all ages—with a tendency on the author's part to regard our socio-economic system as the main cause of it.

A Passage in the Night. By SHOLEM ASCH. 367 pages. Cloth. Putnam. New York. 1953. Price $3.75.

Sholem Asch's latest novel holds particular interest for all those who work professionally with persons suffering from marked feelings of guilt. In his modern drama of man's conflict with a bothersome conscience, Asch deals with the issue of religious versus medical psychotherapy. The implication is that the physician too often lacks a spiritual approach when dealing with a spiritual problem.

"For sicknesses of the soul the psychiatrist, no less than the spiritual guide, must use one method—the method of the eternal conscience. The center of gravity of treatment lies more in the spiritual being, in the moral foundation, of the healer than in the patient."

All of the psychoanalytical terminology and attempts to convince Isaac Grossman that he has "sick hallucinations" fail to help him get well. He recovers only through the ministrations of a rabbi and a priest who help him to atone for his sins through good works.

There are those who will complain that Asch has an incomplete understanding of the methods and goals of medical psychotherapy. Others will feel that the emphasis upon consideration of the possible values of religious therapy is a helpful contribution.

This is not the author's greatest work, but it is still far superior to most current fiction in terms of its powerful characterizations, profoundly moral intentions, and meaningful implications for situations far removed from the frame of reference of one individual with a guilty conscience.

Dynamic and Abnormal Psychology. By W. S. TAYLOR. 658 pages. Cloth. American Book Company. New York. 1954. Price $5.50.

This is a supplementary and reference work for related courses and a text in its own right. It is also a survey for the independent reader.

The dynamic view of abnormal behavior is stressed. In its field the book is thorough. Everyday mental abnormalities, minor mental disorders (psychoneuroses), and major mental disorders (psychoses) are all well covered, with exceptional historical, observational, clinical and experimental background.

Episode. By PETER W. DENZER. 313 pages. Cloth. Dutton. New York. 1954. Price $3.50.

This is the story of Arnold Bronson and his exodus from a neuropsychiatric ward in an army hospital to Farmingdale (the "country club" of mental institutions), thence to a state hospital and finally to freedom and sanity.

There is sensationalism in the description of the army hospital; but except for this, the book is realistic. It is a little better than the average tale of the sort.

Doctors in Blue. The Medical History of the Union Army in the Civil War. By GEORGE WORTHINGTON ADAMS. XII and 253 pages, including preface, appendix with statistical material, index and 16 pages of photographs. Cloth. Schuman. New York. 1952. Price $4.00.

Dr. G. W. Adams, dean and professor of history, Colorado University, deserves great credit for his studiously compiled and fascinatingly presented medical history of the Union Army in the Civil War. For those of us who have experienced twice in our lifetimes the build-up of an army and an army medical corps it is most interesting to follow the author through the fateful years from 1861-1865 when "like all things military in the United States, that department (Medical) was hopelessly amateurish, riddled with incompetence and thoroughly unprepared. By 1865 it was a large, smooth-functioning organization, . . . controlling a system of hospitals more imposing than anything seen to that time."

There were no psychiatric units yet, but already the struggle against war-neuroses—and, with that, the conception of what we would call psychosomatic problems—was going on. Dr. Adams' work is much more than a dry accounting of facts and the scholarly analysis of the "Medical Department of the Army" during this significant and, in its ideology, so far-reaching period; it is a brilliantly written cultural and medical history of this time. Dr. Adams also presents new and important research material which makes his work a valuable reference book.

Not as a Stranger. By MORTON THOMPSON. 948 pages. Cloth. Scribners. New York. 1954. Price $4.75.

A well-meaning, overwritten, excited, but ill-conceived novel about physicians becomes a best seller. The moral precepts are all correct and laudable, the execution is adolescent; a novel should show more than that there are good and bad physicians, those who sacrifice and those who take advantage, those who know and those who are ignorant. Thompson fails to go down to the psychic fabric of people, to show their inner motivations and complexities.

The premise of the novel contains its strongest indictment: "And I knew I must make my hero one of these rarest human creatures, a man *shaped by his genes* to follow a certain course and no other. "Genes do not form "born physicians"; unconscious motivations do. Hence, the hero is obsessed with an idea which the author cannot explain. Even as a person in a novel he is contradictory; he marries a nurse only to get the means to study medicine; and he treats her badly, but only to achieve some reconciliation in the end. This novel makes one think of *Arrowsmith* which, despite its obvious limitations, is a masterpiece by comparison.

The Secret History of Stalin's Crimes. By ALEXANDER ORLOV. 366 pages including index. Cloth. Random House. New York. 1953. Price $4.50.

This is a personal account by a Soviet diplomat and intelligence agent of the bloody years of Stalin's rise to power and maintenance of dictatorship in Russia. A small part of this book appeared serially in a *Life Magazine* condensation. The volume itself, issued just after Stalin's death, predicts that Malenkov "will not start a war before he has consolidated his personal power." A tale like this can, of course, not be documented. It rests upon the good faith of the author and his access to sound information. There seems no reason to question either, and Orlov's account is therefore worth the attention of all.

Life, Faith, and Prayer. By A. GRAHAM IKIN. 127 pages. Cloth. Oxford University Press. New York. 1954. Price $2.50.

In this small book Miss Ikin attempts, what is to the religious mind the ever-provocative, ever-annoying task, the reconciling of scientific inquiry with the religious spirit. Her "purpose is to build a bridge between scientific thinking and religious experience," acclaiming the validity of both, but denying that either is sufficient in itself. In her presentation, she attempts to relate the growth of religious sensitivity with the psychological development of the individual, indicating the concommitant stages of developmental maturity and religious maturity. Written with clarity and psychological insight, this little book is addressed primarily to the layman, to ministers, and teachers.

Music Therapy. Edward Podolsky, M. D., editor. 335 pages. Cloth. Philosophical Library. New York. 1954. Price $6.00.

To the credit of the authors is the lack of preposterous claims for music therapy. Among outstanding contributors are Ira M. Altschuler and Howard Hanson. Music as it relates to and appeals to physiologic patterns is first discussed, followed by a consideration of the effect of music therapy on various mental reactions.

Some attempt at a controlled scientific evaluation is made. The iso-principle is formulated by Dr. Altschuler. A selective control of rhythm, melody, mood and harmony for therapeutics and references to compositions applicable to various disorders are included.

Child With a Flower. By ELDA BOSSI. 205 pages. Cloth. Macmillan. New York. 1954. Price $3.50.

This is a story of the intimate relationship of mother and daughter from the daughter's birth to about four years of age. It is, in effect, the story of all mothers, and is compassionate, warm, remarkably real.

A Social Program for Older People. By JEROME KAPLAN. 158 pages. Cloth. University of Minnesota Press. Minneapolis. 1953. Price $3.00.

Mr. Kaplan presents a comprehensive handbook based on considerable experience as group work consultant to the Hennepin County Welfare Board, Minneapolis. His shift from group work services to youth, where emphasis in schools of social work has long been placed, to group work with our senior citizens has been a profitable one. The rapidly increasing proportion of persons past 65 has stimulated many communities into providing some services to meet a minimum of the social needs of these older people. The author has succeeded in devising social programs which are sensitive to the need of older people to feel they are a productive part of the community.

The formation of clubs, the use of camping, the devising of activities with homes for the aged, are some of the activities around which much thinking has been done. In dealing with so large a group, the need for help from all sources is obvious. Mr. Kaplan delineates the roles of the trained group worker and the volunteer and offers many excellent practical ideas for organizing groups and guaranteeing the utmost participation in them. This book hardly begins to show the resourcefulness of his thinking which gave birth to the concrete program ideas. The success of Mr. Kaplan's groups will also give courage to those whose fear of failure has deterred them from attempting social programs for older people.

Uses and Abuses of Psychology. By H. J. EYSENCK. 318 pages. Paper. Penguin Books Ltd. London. 1954. Price 35 cents.

Dr. Eysenck, a leading English psychologist, has written a sharply critical and provocative book designed to sweep away, or at least lessen, misconceptions regarding a number of popular psychological topics ordinarily entertained by the layman, and not a few professional workers. Reaching broadly over the subject matter of psychology, he comes to grips with socially important concepts, analyzing them in line with modern logic and experimental evidence and procedure.

Among the topics discussed is the general area of intelligence, including special abilities, and the development of children with special abilities (almost a third of the book is devoted to this purpose). As there is a tenacious reluctance among laymen to lay aside their outmoded conception of intelligence, i. e., the absoluteness and psychological reality of the IQ, the author performs a needed service in indicating the relative, and arbitrary nature of all intelligence testing, and the crucial influence of social-cultural environment.

A somewhat polemically presented chapter is devoted to a critical examination of psychoanalysis. Generally, Dr. Eysenck takes a dim view of psychoanalysis, denying that it may be considered a body of science. Among his objections and criticisms are: the untestability of psychoanalytic hypotheses; the tendency to overgeneralize conclusions from specific cases to the total population, particularly with reference to Freud who, Eysenck feels, drew upon a highly unrepresentative sample of late Victorian Viennese; the neglect of control groups to determine the significance of phenomena observed in the ill as contrasted with the healthy; and the formation of "ad hoc" hypotheses such as "reaction formation." While recognizing the importance of Freud's contributions to psychology, he thinks that "psychoanalysis, as a self-contained system claiming to afford a scientific view of human nature is dead. . . . it is to be judged in terms of belief and faith, rather than in terms of proof and verification."

Other topics discussed include techniques of personality evaluation, sexual behavior in our society, and the formation of national character and stereotypes, with an analysis of the development of prejudice.

Generally, Dr. Eysenck has given a clear and careful analysis of current topics of major interest in psychology, presenting views which, while controversial, are, nevertheless, fairly representative of a large part of modern psychological thought. His book is recommended, not only to the layman, but to the professional worker as well.

Steps Forward. Proceedings of the Fourth Mental Hospital Institute. Daniel Blain, M. D., editor. 242 pages. Paper. American Psychiatric Association. Washington, D. C. 1953.

This book records the activities and the ideas (verbatim) of those persons who took part in the Fourth Mental Hospital Institute under the auspices of the APA at Columbus, Ohio, October 1952.

The discussions at that meeting pertained to the following: hospital construction, nursing care, the training of hospital administrators, follow-up of discharged patients, treatment of the psychopath, of the epileptic, methods of handling patients' clothing and the role of the chaplain in a mental hospital. The information given here will be valuable to all mental hospital administrators.

For Boys Only. The Doctor Discusses the Mysteries of Manhood. By FRANK HOWARD RICHARDSON, M. D. X and 91 pages. Cloth. Tupper & Love, Inc. Atlanta. 1952. Price $2.75.

The adolescent boy gets some "facts of life" from the pediatrician in simple, straightforward language. Dr. Richardson's little book gives, frankly, information the boy needs and wants. This one should be kept handy in office, school or home library.

New World of the Mind. By J. B. RHINE. 339 pages including index. Cloth. Sloane. New York. 1953. Price $3.75.

Rhine's *New World of the Mind* brings the report of scientific research into ESP up to date and presents very lucidly Rhine's own concept of the place of his investigations in the scientific world. His position, as well as this reviewer can express it all too briefly, appears to be that science must now take account of well-established phenomena that are not physical. This calls for no credulity and no acceptance of emotionally-motivated, unsubstantiated claims. It does call for research. Among other things this book covers adequately the often overlooked relationship between psychiatry and parapsychology. It is an excellent introduction to the latter field for anybody in the former.

The Age of Suspicion. By JAMES A. WECHSLER. 333 pages including index. Cloth. Random House. New York. 1953. Price $3.75.

As precocious college students in the depressed 1930's, James A. Wechsler and his wife became Communists. He was a member of the Young Communist League for about four years, quitting it in 1937 at the age of 22 and attacking Communism publicly and bitterly ever since. This is his story of being investigated 15 years later on the question of whether he still held in secret the Communist objectives which he had long since publicly renounced. It is a revealing document of the psychology of the public figures lately and now involved in the controversy over the extent of Communism in the United States, and its influence in government. As such, it is well worth the attention of any psychologically-minded social scientist.

The Miracle of Language. By CHARLTON LAIRD. 308 pages including index. Cloth. The World Publishing Company. Cleveland. 1953. Price $4.00.

Charlton Laird's present work is one of the most readable and generally informative this reviewer has encountered on the English language as an instrument of communication, as a cultural expression and as a member of the principal family of the world's great languages. This volume is short; it is apparently authoritative; if there is matter for debate, this reviewer could find no glaring errors; and it should be a valuable addition to the library of any scientist, writer or public speaker.

Your Child Can Be Happy in Bed. Over 200 Ways Children Can Entertain Themselves. By CORNELIA STRATTON PARKER. 275 pages. Cloth. Crowell. New York. 1952. Price $2.95.

Here are hundreds of practical, inexpensive suggestions for children and harried adults, not only useful when a child is sick, but also excellent source material for raising any children happily.

Understanding That Boy of Yours. By MELBOURNE S. APPLEGATE. 52 pages. Paper (pamphlet). Public Affairs Press. Washington, D. C. 1953. Price $2.00.

In a brief pamphlet, Melbourne S. Applegate has written one of the most succinct credos on *Understanding That Boy of Yours.* It is not only a succinctly sound brochure of inestimable value to all social scientists; it is an informative, clear, coherent statement of faith and fact. Mr. Applegate replaces emotionalism with understanding in commenting intelligently on psychological problems relating to dealing with one's boy: how to interpret his actions rightly, his need for encouragement in adolescence, vocational guidance matters, the use of leisure wisely, and, generally, the need of being a friend to the boy.

Understanding That Boy of Yours is a more worthwhile compilation of information and data, coupled with ideas and attitudes, related to youth than may be found in many voluminous texts in the field of sociology and psychology.

Unfair Comment Upon Some Victorian Murder Trials. By JACK SMITH-HUGHES. 360 pages. Cloth. British Book Centre. New York. 1951. Price $4.50.

This is a series of somewhat irreverent sketches and comments on certain British murder trials which were *causes célèbres* of the mid-Victorian era. The writing is sprightly; the author does not moralize and the atmosphere of discussion is considerably lighter than in the average volume of the *Notable British Trials Series*—to which this book does not belong. The author is a British barrister who notes that he has been able to discuss certain matters which it would have been "unprofitable (or worse)" to discuss during the lifetimes of the acquitted defendants. The student of human motive and of criminology will be interested in this collection, as will many mystery story addicts.

Captain John Smith. By BRADFORD SMITH. 375 pages. Cloth. Lippincott. Philadelphia. 1953. Price $5.00.

This is an attempt to re-evaluate the life and accomplishments of a man who has become a folk-hero to school children and has been labeled a braggart and a liar by professional historians. The author definitely tends to give Smith the benefit of the doubt on many items called in question—perhaps without justification. But a close study of contemporary sources has so often proved Smith right and his detractors wrong that this is excusable. The author shows a knowledge of psychiatric principles, particularly when recognizing Smith's search for a mother figure, but this aspect of the biography plays a very minor role.

Destiny and Motivation in Language. By A. A. Roback. 474 pages. Cloth. Sci-Art. Cambridge. 1954. Price $8.50.

This is a book of essays and notes on psycholinguistics. It will appeal to any member of the great legion of admirers of A. A. Roback and will interest besides almost any educated person who happens to share Roback's views that the psychodynamics of language have still been all too little explored. The author draws on a sound knowledge of psychology and a wide acquaintance with the world's languages and with linguistic and psychological literature. This is not an integrated book. It jumps from historical symbolism to names, to popular and "phony" etymology, to psychoanalytic implications of language, to Latin, to the Semitic tongues and back again. This is likely not a fault; it makes the work all the easier to enjoy by somebody who can spare only a few moments at a time for its reading.

Dr. Roback presents his own voco-sensory theory of the origin of words. Among the modern tongues he devotes a great deal of attention to Yiddish, and he dedicates his work to "the memory of four-and-a-half million Yiddish speakers destroyed by governmental decree"—Nazi and Communist. Roback's dynamic treatment of language seems to be a natural part of the dynamic treatment of other mental phenomena, and anybody concerned with human psychodynamics can properly be concerned with this.

The Hidden Face. By Marie Baumer. 216 pages. Cloth. Scribner's. New York. 1953. Price $3.00.

A psychopath is brought into a circle of neurotic friends, upsetting the balance temporarily. His suicide after he is dropped from the group when a hoax he perpetrates is discovered is a conceivable impulsive gesture. The characters are psychiatric stereotypes in an emotional vacuum. The book is not good literature, frequently is trite, and would seem to have no value as bibliotherapy.

Fiesta. By Prudencio De Pereda. 359 pages. Cloth. Wyn. New York. 1953. Price $3.75.

This is an unfortunate book which, despite cultured language and mechanical skill of presentation, emanates boredom. The plot is about a small Spanish town and the rivalry of five men fighting for the honor to portray Christ in the local Passion Play.

Bringing Up Parents. A Biography in Verse. By Sima Rubenz. 96 pages. Cloth. Exposition Press. New York. 1952. Price $2.50.

If you enjoy baby talk, pre-school lisping and an all-too-adoring set of parents, you'll get your fill on this one. Of interest to the friends and family of the author exclusively!

The Supernatural in Fiction. By PETER PENZOLDT. xii and 271 pages. Cloth. British Book Centre. New York. 1953. Price $4.50.

The author announces himself to be in sympathy with the Jungian theories—for which announcement this reviewer is grateful. On most matters, Penzoldt writes far more like a Freudian than a Jungian, and he succeeds in giving comprehensible explanations for the motivations behind writing certain forms of supernatural fiction; such as guilt feelings in the tale of pure horror, as exemplified by Arthur Machen. As regards literary criticism, the author's judgment is sound, excusing, of course, a certain enthusiasm for his own field.

Ways Towards Self-Discipline. By GENEVIEVE L. COY. 95 pages. Paper. The Dalton Schools, Inc. New York. 1950. Price not indicated.

"The Staff of the Dalton School," states the author, "is convinced that the development of character and personality should be one of the major aims of education." This text describes some of the methods and procedures the Dalton School uses to accomplish this purpose. It is doubtful if any new ideas have been contributed to the theory of discipline; but it is interesting to note how the matter is being handled in one particular institution.

Trial of John George Haigh. Lord Dunboyne, editor. 271 pages. Cloth. British Book Centre. New York. 1953. Price $3.25.

John George Haigh was hanged in a British prison in 1949 after conviction for the murder of an aged woman for money and the confession of seven more killings, two of them imaginary. Haigh dissolved, with acid, the body of the woman for whose killing he was convicted. He drank, or said he drank, a cup full of blood from each of his victims. His insanity defense, however, failed, and, regardless of possible actual psychosis, it is plain that he was malingering. The trial is, of course, of particular interest in the field of forensic psychiatry.

Hell's Cauldron. By THOMAS G. E. WILKES. 274 pages. Cloth. Stratton-Wilcox Co. Atlanta, Ga. 1953. Price $3.75.

Apparently, the author wrote this book to prove to himself that he was not mentally ill and to give readers an idea of the "horrible" things and the chicanery which went on in neuropsychiatric units in army and V. A. hospitals.

Psychiatrists who were in army hospitals during the last war remember the "red tape" and slow processing; but the conditions which Capt. Wilkes describes could not reach the extent to which he believes they went, because there were too many checks and double-checks.

The last phrase in the book is, "Just who was crazy?" This, each reader will have to decide for himself.

The Making of a Moron. By NIALL BRENNAN. 189 pages. Cloth. Sheed & Ward. New York. 1953. Price $2.50.

The author of this book, inspired by experiments demonstrating that mental defectives can adequately perform many of the routine jobs demanded by industry, has attempted to investigate the effects of the type of work they can do upon the nature of normal man. Mr. Brennan's findings are based upon personal experiences from a succession of various employments in factories, mills, and department stores. In an analysis of this data, he contends that many of the jobs essential to modern industry blunt, stultify, and finally "mutilate" man's personality. His solution of the problem facing modern man in industry revolves about a religious and spiritual philosophy.

The Dreamboaters. By LARRY FRISCH. 122 pages. Cloth. Exposition Press. New York. 1953. Price $2.75.

This is a plausible story of a young girl's drug addiction and subsequent degradation. As propaganda material, it paints a sordid picture of young addicts, but fails to show adequately how victims are pre-conditioned for addiction, or the possibilities of rehabilitation. In the preface, the author states that veterans returned from Asiatic experience are a narcotic threat to the home community—without providing the relative background of the far more dangerous professional seducer and racketeer. The book serves no literary or mental hygiene propaganda value.

Foundations of Mental Health. By "A Psychiatrist." 29 pages. Paper. June 1953. (Journal of The Christchurch Psychological Society, Number 3.)

"The content of this number is a series of talks on Mental Health broadcast by stations 3yc and 3ya of the New Zealand Broadcasting Service.

"Being broadcast talks, and not addresses, they were given in colloquial form; and are reproduced here just as they were given."

The first talk is an introduction to the field of psychiatry for the layman; the following six are in question-and-answer form. This is an interesting booklet, well worth the half-hour necessary to read it.

The Soup Stone. By MARIA LEACH. 160 pages. Cloth. Funk and Wagnalls. New York. 1954. Price $2.75.

The story of the soup stone must originally have been a little fable about the source and fountainhead of all good things. As related here, it is an entertaining tale of a trick. It is one of a collection of little tales on subjects ranging from panties to hiccups to Old Mother Twitchett. This book should entertain almost anybody from a child to the sophisticated—the psychodynamics are largely omitted.

How to Help People. By RUDOLPH M. WITTENBERG. 64 pages. Cloth. Association Press. New York. 1953. Price $1.00.

Under a broad, deceptive title appears a very brief condensation of an earlier book, *So You Want to Help People.* The primary concern of the author is in helping lay youth leaders, Y. M. C. A. directors, church workers, and the like, in their understanding of child and adolescent social adjustment problems, on a very practical and rudimentary level. Written in an easy, popular style, this small handbook may prove of limited value to the layman, but would hardly be of much utility to the professional reader.

Diplomatic Diversions. By ROGER PEYREFITTE. 279 pages. Cloth. Vanguard Press. New York. 1953. Price $3.00.

This is a competent translation from the French of *Les Ambassades,* which is described as a lively and cynical novel of diplomatic doings in Athens just prior to World War II. It should be of psychiatric interest because it is compounded largely of ingredients suitable for *Psychopathia Sexualis,* including bawdy houses, seductions, resorts where boy meets boy, and apparently conscious but suppressed homosexuality in addition to the overt performances. This unpleasantness, however, is handled in so superficial and uncomprehending a fashion as to be too trivial for anybody's serious attention.

The Golden Spike. By HAL ELLSON. 243 pages. Paper. Ballantine Books. New York. 1952. Price 35 cents.

This is a novel about drug addiction in adolescents; though the genetic basis is not even touched upon, the phenomenology is well worked out; the book is worth reading.

Karen. By MARIE KILLILEA. 314 pages. Cloth. Prentice-Hall. New York. 1952. Price $2.95.

Karen is a description of the desperate fight of a mother for a girl afflicted with cerebral palsy. Bitterness and real mother love are intermingled. The book is honest, and deserves a hearing.

Glands, Sex, and Personality. By HERMAN H. RUBIN, M. D. X and 205 pages. Cloth. Wilfred Funk. New York. 1952. Price $2.95.

This is an easy-to-read book for the layman on the endocrine glands and their hormones. The author outlines the conditions resulting from their malfunctioning and the recent achievements in the field of prevention and treatment.

CONTRIBUTORS TO THIS ISSUE

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Born in New York City, he received his bachelor's degree from Clark University in 1929, his Ph.D. in anatomy from Cornell in 1933, and his medical degree from the University of Georgia in 1937. He has been a member of the faculties of St. Louis, Georgia, Rutgers, Harvard and Rochester universities, and has been with the College of Physicians and Surgeons since 1941. Dr. Mettler is a member of numerous professional societies, not only in medicine but in related social sciences. He has contributed more than 150 articles to scientific journals, including this QUARTERLY. He is married and has two children.

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Dr. Weiss received his master of public health degree from Yale in 1951. He has been visiting consultant to the New York State Mental Health Commission, and is a member of the American Public Health Association, the American Psychiatric Association, and other professional organizations. He is the author of several papers on psychiatric and mental hygiene subjects.

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He was graduated from the University of Rochester Medical School in 1944 and served a nine-month rotating internship at Michael Reese Hospital in Chicago. Thereafter, he served two years in the Army Medical Corps where he reached the grade of captain. His subsequent residency training in neuropsychiatry was at Veterans Administration units in the Boston area. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology and a member of the American Psychiatric Association and other professional societies.

J. W. KLAPMAN, M. D. Dr. Klapman was graduated from Northwestern University Medical School in 1925 and was in general private practice in Chicago from 1925 to 1931 when he entered the service of the Illinois Public Welfare Department. He was on the faculty of Northwestern University Medical school from 1940 to 1947. He has served on the staffs of several Illinois state institutions and at the present time is on the staff of the Chicago Community Clinic. He has contributed a number of papers to psychiatric journals and is the author of *Group Psychotherapy; Theory and Practice.*

CHARLOTTE BUHLER, Ph.D. Dr. Buhler is assistant clinical professor of psychiatry at the University of Southern California Medical School. She is a diplomate in clinical psychology of the American Psychological Association and has a private psychotherapeutic practice in Beverly Hills, Calif. She has taught at several universities in the United States and in

Europe, and was formerly associate professor of psychology at the University of Vienna. She has been a director of guidance clinics in both Europe and the United States and has twice held Rockefeller fellowships. Her many publications are mainly in the field of developmental and clinical psychology. She is the wife of Karl Buhler, M. D., Ph.D., with whom she is associated in the private practice of psychotherapy.

BENJAMIN MALZBERG, Ph.D. Dr. Malzberg has been with the Bureau of Statistics of the New York State Department of Mental Hygiene since 1928, as senior statistician and assistant director until 1944, and as director since that time. A graduate of the College of the City of New York and of the New York School of Social Work, he has A. M. and Ph.D. degrees from Columbia. He also has studied sociology at the University of Paris and University College, London, on a field service scholarship. He was statistician of the New York State Board of Charities for five years before joining the Department of Mental Hygiene. Dr. Malzberg is the author or co-author of numerous books and scientific articles on the statistics of mental disorder.

NEWS AND COMMENT

DRS. BRILL AND TERRENCE ARE NAMED ASSOCIATE EDITORS OF PSYCHIATRIC QUARTERLY

Assistant Commissioner Henry Brill, M. D., of the New York State Department of Mental Hygiene, and Director Christopher F. Terrence, M. D., of Rochester (N. Y.) State Hospital, have been named associate editors of THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT.

Dr. Brill has been with the New York State hospital service for 22 years, Dr. Terrence for 21. Both are particularly interested in administration, training and the therapy of mental illness, including the organic therapies.

Born in Bridgeport, Conn., in 1906, Dr. Brill was graduated in 1928 from Yale College, where he was a member of Phi Beta Kappa and the holder of several scholarships. Graduated from Yale Medical School in 1932, he has been with the New York State service ever since. He became assistant commissioner of the Department of Mental Hygiene in 1952 after having served as director of Craig Colony for two years; he had previously been acting associate director at Pilgrim. He is a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology.

Dr. Terrence has been director of Rochester State Hospital since 1951, a position to which he was appointed from the assistant directorship of Brooklyn State Hospital. Born in Brooklyn, of a family which had lived there for four generations, he attended elementary and high school and St. Francis College there, and received his medical degree from the Long Island College of Medicine in 1931. He interned at Kings County Hospital, Brooklyn, entered the state service in 1933 and had been assistant director at Brooklyn for nine years when he was appointed to the Rochester directorship.

Dr. Brill is author or co-author of a number of scientific papers on shock therapy and on prefrontal lobotomy. Dr. Terrence was one of the early users of insulin and metrazol shock and has personally assisted at more than 300 lobotomy operations.

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WHITTIER, NEW CREEDMOOR RESEARCH DIRECTOR

John R. Whittier, M. D., of Englewood, N. J., has been appointed by Commissioner Newton Bigelow, M. D., of the New York State Department of Mental Hygiene, to direct research at the Creedmoor Institute of Psycho-

biologic Studies at Creedmoor State Hospital, Queens Village, N. Y. His appointment is effective July 1, 1954; and his title is principal research scientist in psychiatry.

Dr. Whittier will direct research particularly into the mental disorders of older persons, and the institute's studies of histamine and glutamic acid in the treatment of mental illness will be continued. There will also be a general program to explore the integration of such related specialties as neuro-anatomy, neurophysiology, pharmacology and psychology in treatment and prevention programs.

Born in Washington, D. C., the son of an army physician, Dr. Whittier spent his boyhood and youth in the Philippines, Panama, Minnesota and Texas, attended St. Mary's University in San Antonio, Texas, and Harvard College. He received his M. D. from the College of Physicians and Surgeons, Columbia University, in 1943, interned at Gorgas Hospital, Ancon, Panama Canal Zone, and served a psychiatric residency at the Neurological Institute of New York and the Bronx Veterans Administration Hospital. After nearly three years in the army, he was discharged in 1946 with the rank of captain and went into research work in the neurology department of Columbia University. He has been in private practice in neurology and psychiatry in New Jersey for the last four years, and is completing this year a three-year course of training and experience at the Columbia Psychoanalytic Clinic for Training and Research.

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JOHNSON TO HEAD STUDY OF MENTALLY RETARDED

A pilot study to determine the possible extent of education and training of the mentally retarded under a $50,000 appropriation by the New York State Legislature, will be headed by Dr. G. Orville Johnson, a widely-known authority in the field, it has been announced by Commissioner Newton Bigelow, M. D., of the New York State Department of Mental Hygiene. The study will be under the direction of the State Mental Health Commission and will cover five state school classes at Letchworth Village and Willowbrook State School, and seven classes in the public school system.

Dr. Johnson has taught, supervised studies, organized training school programs and conducted research in Wisconsin, Illinois and Colorado. He is now on the faculty of Syracuse University. He is co-author of *Educating the Retarded Child,* generally recognized as the basic textbook in the field, and is author of numerous articles, in various professional journals, on the mentally retarded.

LUDWIG JEKELS, M. D., PSYCHOANALYST, DIES AT 87

Ludwig Louis Jekels, M. D., psychiatrist, psychoanalyst, friend and pupil of Sigmund Freud and frequently considered the dean of American psychoanalysis, died in his sleep at his home in New York City on April 3, 1954. He was 87 years old. Born in Austria in 1867, a graduate of the University of Vienna in medicine in 1892, Dr. Jekels did postgraduate work at Vienna Hospital for five years before founding a sanatorium in Silesia for the treatment of nervous disorders.

He became a pupil of Freud in 1905 and practised psychiatry in Vienna until 1935 when he moved to Sweden. He came to the United States in 1938; and he remained in psychiatric practice until his death. Dr. Jekels was widely known in both Europe and this country as a psychoanalytic writer as well as a practitioner. He wrote a number of papers on the applications of psychoanalysis to history and literature, including monographs on *The Turning Point in the Life of Napoleon, The Riddle of Shakespeare's Macbeth,* the *Psychology of Comedy,* and the *Psychology of Pity.* With Edmund Bergler, M. D., he wrote papers on instinctive dualism in dreams and on transference and love. Dr. Jekels leaves his wife and a daughter, the wife of Dr. Emery Wells of New York City.

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STANLEY COBB, PSYCHOSOMATIC SOCIETY PRESIDENT-ELECT

Stanley Cobb, M. D., was named president-elect of the American Psychosomatic Society at the organization's annual business meeting on March 27, 1954. Other officers are: Lawrence S. Kubie, M. D., president; Theodore Lidz, M. D., secretary-treasurer; and Dane G. Prugh, M. D., David Shakow, Ph.D., and Stewart Wolf, M. D., council members. The association's 1955 annual meeting has been announced for May 4 and 5 in Atlantic City.

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CAROLINE F. J. RICKARDS, M. D., DIES AT 81

Dr. Caroline F. J. Rickards, who, at her retirement at 80 a year ago, was one of the oldest practising women physicians in the country, died at Roslyn Heights, New York, on April 23, 1954 at the age of 81. A graduate of the Women's Medical College of Pennsylvania in 1894, she had conducted a psychoanalytic practice in New York City in recent years.

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C. I. LAMBERT, M. D., FOUR WINDS DIRECTOR, DIES AT 76

Charles Irwin Lambert, M. D., neurologist, psychiatrist, specialist in child psychiatry, educator, and medical director of Four Winds, a sanatorium at Katonah, N. Y., died on April 11, 1954 in a United States Air Force Hospital at Casablanca, Morocco, where he had been rushed after a heart attack while on a cruise abroad. He was 76 years old.

A graduate in medicine of the State University of Iowa, Dr. Lambert taught there for a year before joining the New York State hospital system as an assistant in neuropathology at the New York State Psychiatric Institute in 1905. He remained at the institute, then on Ward's Island, until 1913, serving for part of that time as pathologist of Manhattan State Hospital, and leaving to become assistant director of Bloomingdale Hospital, now the Westchester Division of New York Hospital. He later was director of the psychiatric department of the Vanderbilt Clinic, was professor of psychiatric education at Teachers College, Columbia University, and associate professor of psychiatry at the College of Physicians and Surgeons. He had recently been in semi-retirement although continuing to hold the position of medical director at Four Winds.

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MINNESOTA ANNOUNCES CONTINUATION COURSE

The University of Minnesota Medical School announces a three-day continuation course in "Psychiatric Principles in General Practice" to be conducted at Douglas Lodge, Lake Itasca, Minn., at such hours that those in attendance will be free after mid-afternoon for fishing, boating and other recreation; the fee will provide for fishing licenses, besides transportation from Minneapolis, meals, lodging and tuition. Bernard C. Glueck, Jr., M. D., senior psychiatrist at Sing Sing Prison and director of the New York State Sex Delinquency Research Project, will be a member of the guest faculty. Director of the course will be Dr. Donald W. Hastings, professor and head of the department of psychiatry and neurology and director of the division of psychiatry, the University of Minnesota Medical School; and the rest of the faculty will be from the medical school and the Mayo Foundation. The brief course will emphasize practical management in the psychiatric and psychosomatic problems most often met in general practice. It will be conducted September 8-10, 1954.

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NEW CHILD MENTAL HEALTH PAMPHLET ISSUED

The National Association for Mental Health has issued a new folder, *What Every Child Needs for Good Mental Health*, now available for general distribution. The pamphlet lists as essentials: love, acceptance, security, protection, independence, faith, guidance and control—with brief notes on each and small sketches for illustrations. The pamphlets may be ordered from the National Association for Mental Health, 1790 Broadway, New York 19, N. Y., at $1.10 for 100 and somewhat lower prices for orders of 1,000 or more.

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